

PARTICIPANT MANUAL

Tennessee Department of Health Bureau of Alcohol and Drug Abuse Services

CONTRIBUTORS TO THE DEVELOPMENT OF THE CO-OCCURRING DISORDERS PROJECT

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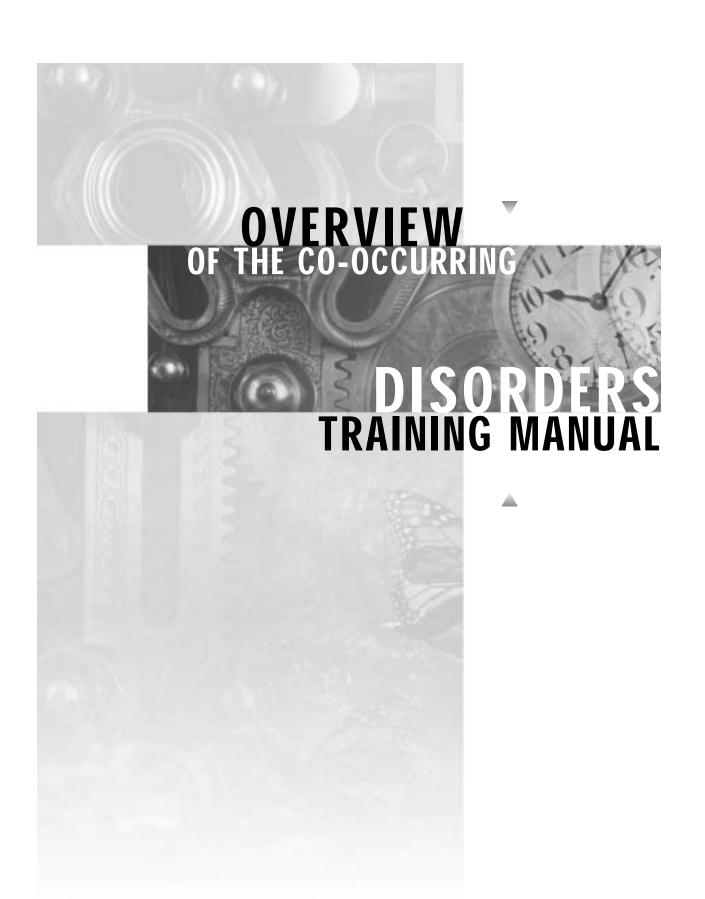
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PURPOSE

Recognizing the significant differences of the treatment needs of patients with either an AOD use disorder or a psychiatric disorder by itself, this training manual was developed. Its' purpose is to introduce participants to the unique treatment needs of patients who have a psychiatric disorder *in combination with* an alcohol and other drug (AOD) use disorder.

This manual explores mental health disorders, alcoholism and drug addiction, and cooccurring disorders. It also familiarizes the participant with the unique treatment concerns for the co-occurring disordered population covering information and treatment recommendations that can be used by healthcare providers in a variety of treatment settings (primary care clinics, hospitals, and mental health centers).

LEARNING OBJECTIVES

As a result of participation in this training, participants will be able to:

- Define the global definition of addictive disorders, psychiatric disorders, cooccurring disorders, and interaction.
- List the key features within each edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM)
- Define the disease model of addiction.
- Define substance abuse and substance dependence.
- List at least three abused substances associated with Co-Occurring Disorders
- Define mental illness.
- List at least three warning signs of mental illness in adults.
- Identify the most common mental health disorders associated with Co-Occurring Disorders.
- Differentiate the concepts of sequential, parallel, and integrated treatment.
- Recognize general elements of integrated treatment that span treatment contexts.
- Identify methods to improve individual approached to assessment and treatment of Co-Occurring Disorders.

- Introduce the workings of the brain
- Recognize the neuro-biological basis for mental illness and addiction
- Recognize the role of medication in the healing process.
- Illustrate that medication properly prescribed and monitored can positively impact the epidemic of addiction and chronic relapse typically seen in the mental health and addiction populations.
- Re-tool Professionals, Stakeholders and Clients with the knowledge that
 pharmacology is key in the treatment of co-occurring illness and that we must
 change our mindsets and attitudes based on a merging of treatment strategies
 and philosophies.
- Define the key life domains of collaborative systems and key values of community based care.
- Identify the unique needs and characteristics of individuals with a co-occurring disorder that impact coordination of and access to services.
- Define coordination, reasons foe and major mechanisms for coordinating treatment services with support services.
- Identify a process for assessing their agencies and communities strengths and weaknesses for coordination of care and identify a process to improve upon collaboration in their practice and community.

INTENDED AUDIENCE

This training program is designed for substance abuse program administrators, substance abuse counselors, mental health administrators, mental health counselors, health care providers, and other individuals who have an interest in co-occurring disorders.

HOW TO USE THIS MANUAL

This training manual is intended to provide materials and instruction for conducting a 1-day training session on co-occurring disorders. The material is divided into six modules, each lasting approximately 60 to 90 minutes. *Trainers should examine all materials and activities before conducting the training.* The manual also includes lecture topics and key points, questions for discussion, recommended materials and methods for implementing the training, suggested overheads, and handouts.

It is recommended that trainers use their own resources, illustrations, and anecdotes to design an engaging and worthwhile learning experience for participants. If necessary, trainers may also want to role model some of the exercises for participants having trouble understanding the instructions. Trainers should also adjust content and examples to be personally relevant and appropriate to the participants. Special consideration should be given to the ethnic and cultural differences among participants.

Each module begins with an overview of the material contained in the module and the following information about the process:

- Time Needed
- Methods of Instruction
- Goal
- Objectives
- Key Points
- · Materials Needed
- Overhead / Notes
- Supplements
- Prepared Newsprint

This information should be reviewed prior to conducting the training, and the trainer should be familiar with each module's goals, objectives, and key points. Materials should be obtained, handouts copied, and newsprint prepared in advance of the training. Note that the overview of the training module lists "prepared newsprint," "overheads," and "supplements," and the training plan for the module indicates places where they are to be used. In preparation for training, trainers should write each newsprint topic at the top of a page; participants' comments should be recorded on the page during group brainstorming sessions and discussions. The trainer should prepare and practice the lectures and be familiar with the instructions for exercises and questions for discussion.

Each training module also includes a schedule that lists activities, allotted times, and the training methods to be used. The actual content of the modules is contained on pages with two columns. The left-hand column includes:

- · The activities
- Training methods
- Time allotments, with sub-activity times indicated in parentheses

- · References to overhead / notes
- References to supplements
- · References to prepared newsprint

The right-hand column contains directions for conducting activities, including lecture material, instructions for exercises, and questions for discussion.

MAJOR TOPICS

Six major modules comprise the Co-Occurring Training Manual. They are:

Module One Ground Zero: Definitions & Framework

Module Two Let's Talk About Substance Abuse

Module Three Let's Talk About Mental Health Disorders

Module Four Treatment of Co-Occurring Disorders

Module Five Pharmacology

Module Six Collaborative Systems

METHODS

The training curriculum uses a combination of adult learning techniques and contains activities that focus on specific objectives and provide opportunities for learners to participate. Techniques are varied to maintain learner interest. These include:

- Brief lectures
- Small-group assignments
- Large-group discussion
- Exercises
- · Case studies

TIME AND ORGANIZATION

The total time for this training program is about 7 hours. With 1 hour for lunch and two 15-minute breaks, the total workshop time is about 8 hours. The curriculum is composed of six modules: Four are approximately 60 to 90 minutes in length, and two are about 90 minutes. However, time requirements for presenting the training may be affected by many factors, such as the number of participants, their level of knowledge and experience, and the amount of time available.

While the curriculum is designed so that the presentation time can be increased or reduced to meet the demands of the situation, suggested time allotments are included in each section. Time allotments are based on an optimal group size of 15. If there are considerably more or fewer than 15 participants in training session, times allotted to some exercises will vary considerably. In addition, programs may want to schedule additional time for participants to practice what they have learned.

An alternate training format would be to present one or two modules over a series of evening time slots or one module during a lunchtime slot over a period of 6 days. To maintain momentum and continuity, it is recommended that there be no longer than 1 week between presentation of the modules.

CLASS SIZE—TRAINER/TRAINEE RATIO

- 1 2 trainers
- 9 30 trainees

If two trainers are used, one can give instructions while the other records. Alternating trainers promotes participant attention.

TRAINER QUALIFICATIONS

It is recommended that, when possible, two trainers work as a team to present this curriculum. Trainers should be experienced in the issues of substance abuse and mental health treatment. It is also desirable that trainers have a basic understanding of co-occurring disorders. Given the requirements of this training task, it is important that trainers have the following qualifications.

- Training and group facilitation skills;
- Knowledge of substance abuse and mental health treatment;
- Knowledge of adult learning theory;
- Ability to adjust delivery to diverse learning needs; and
- Up-to-date knowledge of co-occurring disorders issues, principles, and practices.

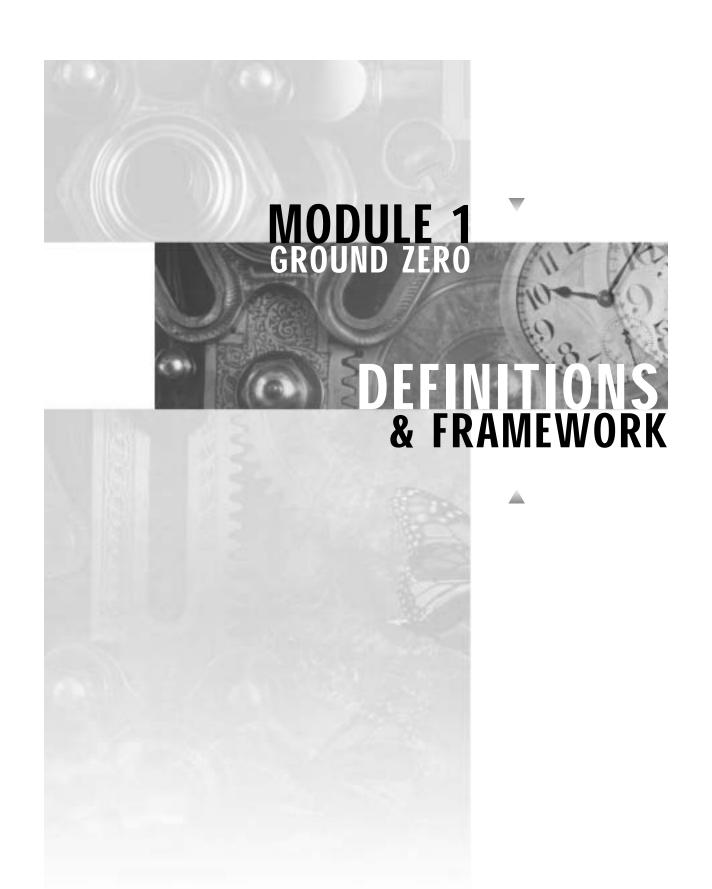
TRAINING AIDS

All the materials developed for this curriculum may be reproduced for instructional purposes. Overhead / Notes are designed to facilitate easy note taking for the participants. Prior to delivering the training, trainers should prepare the newsprint.

Alternatively, trainers may want to consider including excerpts from Assessment and Treatment of Patients with Co-Existing Mental Illness and Alcohol and Other Drug Abuse, Treatment Improvement Protocol (TIP) Series #9; or other materials in the NIDA set of materials.

ROOM AND EQUIPMENT REQUIREMENTS

- Meeting room large enough to hold the group or breakout rooms, so participants can work in small group teams
- U-shape or conference-style seating arrangement
- Prepared newsprint and easel
- Markers of various colors (at least two)
- Tape
- Notepads and pencils
- Overhead projector
- Screen
- Overhead transparencies
- VCR player and monitor
- Watch



GROUND ZERO:

DEFINITIONS AND FRAMEWORK

OVERVIEW

Most identified psychiatric patients only use psychiatric services. Generally they are underdiagnosed and do not receive comprehensive treatment for addictive disorders. On the flip side of the coin, most identified addictive disorders only receive addiction treatment. Symptoms may be misinterpreted and the patient receives neither a psychiatric evaluation nor psychiatric treatment in addition to the addiction treatment.

The <u>DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (DSM)</u> is periodically updated and produced by the American Psychiatric Association. It is used throughout the medical and mental health fields for diagnosing psychiatric and alcohol and other drug use disorders providing clinicians with a common language and for making clinical decisions based on current knowledge.

Time Needed	1 hour
Methods:	Lecture (30 minutes) Discussion (30 minutes)
Goal:	To introduce participants to an integrated concept of behavioral health
Objectives:	 By the end of module I, participants will be able to: Define the purpose of the training. Review the course learning objectives. Define the global definition of addictive disorders. Define the global definition of psychiatric disorders. Define the global definition of co-occurring disorders. Define the global definition of interaction. List the key features within each edition of the DSM.
Key Points:	 Establishing a consistent definition and language of addictive disorders, mental health disorders, co-occuring disorders, and their interaction. This first edition of the DSM prohibited alcoholism or drug addiction from being separately diagnosed from other disorders and suggested dependence stemmed from an "underlying disorder".
Materials Needed:	 Prepared newsprint and easel Markers Tape Notepads and pencils

GROUND ZERO: DEFINITIONS AND FRAMEWORK

	Overhead projectorScreenOverhead transparenciesWatch
Overhead / Notes:	 1.1 Purpose of Training 1.2 Course Learning Objectives 1.3 Module One Objectives 1.4 Definition of Addictive Disorders 1.5 Definition of Psychiatric Disorders 1.6 Definition of Co-Occurring Disorder 1.7 Definition of Interaction 1.8 DSM - What Is It? 1.9 Evolution of the DSM
Handouts:	 1.1 Assessment and Treatment of Patients with Co-Existing Mental Illness and Alcohol and Other Drug Abuse, Treatment Improvement Protocol (TIP) Series #9 1.2 Dual Diagnosis Recovery Network, Directory of Dual Recovery Resources
Prepared Newsprint:	 1.1 Hopes 1.2 Fears 1.3 Class Norms 1.4 Parking Lot 1.5 Two Blended Circles

GROUND ZERO: DEFINITIONS AND FRAMEWORK

Overhead 1.1

THE PURPOSE

...is to introduce participants to co-occurring disorders and enhance their ability to assess and treat the co-occurring population.

GROUND ZERO: DEFINITIONS AND FRAMEWORK

Overhead 1.2

COURSE LEARNING OBJECTIVES:

- Define the global definitions of, addictive disorders, psychiatric disorders, co-occurring disorders, and interaction.
- List the key features within each edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).
- Identify the most common mental health disorders associated with Co-Occurring Disorders.
- Identify the most common substances abused associated with Co-Occurring Disorders.
- Identify and discriminated between acute primary psychiatric disorders and psychiatric symptoms caused by alcohol and other drugs (AODs).
- List the three treatment models of Co-Occurring Disorders.
- Screen clients for mental health disorders and drug dependence.
- Define the Federal Confidentiality Law, Federal Controlled Substance Law, Tennessee Mental Health Commitment Law, and the Tennessee Alcohol and Drug Treatment Law:
- Become familiar with the pharmacological management of Co-Occurring Disorders.
- Become familiar with Tennessee's Dual Disorders Program, Alcohol and Drug Programs, Mental Health Programs and Dual Recovery Anonymous.

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GROUND ZERO: DEFINITIONS AND FRAMEWORK

Overhead 1.3

MODULE I - OBJECTIVES

- Define the purpose of the training.
- · Review the course learning objectives.
- Define the global definition of addictive disorders.
- Define the global definition of psychiatric disorders.
- Define the global definition of co-occurring disorders.
- Define the global definition of interaction.

Module 1: Ground Zero: Definitions & Framework

• List the key features within each edition of the DSM.

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GROUND ZERO: DEFINITIONS AND FRAMEWORK

Overhead 1.4

ADDICTIVE DISORDERS

An Addictive Disorder is the preoccupation with acquiring alcohol and drugs, compulsive use of alcohol and drugs despite adverse consequences, and a pattern of relapse to alcohol and drug use despite the recurrence of adverse consequences.

Central to addiction is a loss of control over alcohol and drug use, which leads to consequences that are harmful to the individual and other, associated with him or her. This loss of control is what makes an addiction a disease or disorder, similar to other diseases/disorders such as schizophrenia or diabetes.

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GROUND ZERO: DEFINITIONS AND FRAMEWORK

Overhead 1.5

PSYCHIATRIC DISORDERS

A Psychiatric Disorder is a collection of psychiatric symptoms (pathological or abnormal psychological) which occur in a predictable pattern that is considered sufficiently unique to have its own diagnosis and course. An example is schizophrenia, where hallucinations and delusions occur with personality changes that begin in adolescence and can progress over a lifetime.

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GROUND ZERO: DEFINITIONS AND FRAMEWORK

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Overhead 1.6

CO-OCCURRING DISORDER

The strict definition of *co-occurring disorders* means that another disorder exists independent of an addictive disorder. The key words are another and independent.

Another means that any psychiatric or medical disorder coexists with or occurs in addition to the addictive disorder. Simply, two or more independent disorders exist in the same individual.

Independent means that each disorder has a life of its own and is not dependent on the other for its cause or continuation.

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GROUND ZERO: DEFINITIONS AND FRAMEWORK

Overhead 1.7

INTERACTION

The *interaction* between addictive and psychiatric disorders is of paramount importance. While psychiatric disorders do nto cause addictive disorders, they can influence the individual's ability to accept treatment for them. At the same time, because addictive disorders can cause psychiatric symptoms that look like psychiatric disorders, addictive disorders must be distinquished from psychiatric disorders. If addictive disorders are not considered independent, drinking or drug use will be attributed to other disorders or causes. If this happens, there will not be proper diagnosis or treatment of either the addictive or psychiatric disorder. Moreover, treatment of the psychiatric disorder will be difficult and often impossible because of the uncontrolled nature of addictive disorders.

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GROUND ZERO: DEFINITIONS AND FRAMEWORK

Overhead 1.8

DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS

What is It?

- Common language and for making clinical decisions on mental disorders,
- · Based on current knowledge,
- Used throughout the medical and mental health fields,
- Is periodically updated, and

Module 1: Ground Zero: Definitions & Framework

• Produced by the American Psychiatric Association.

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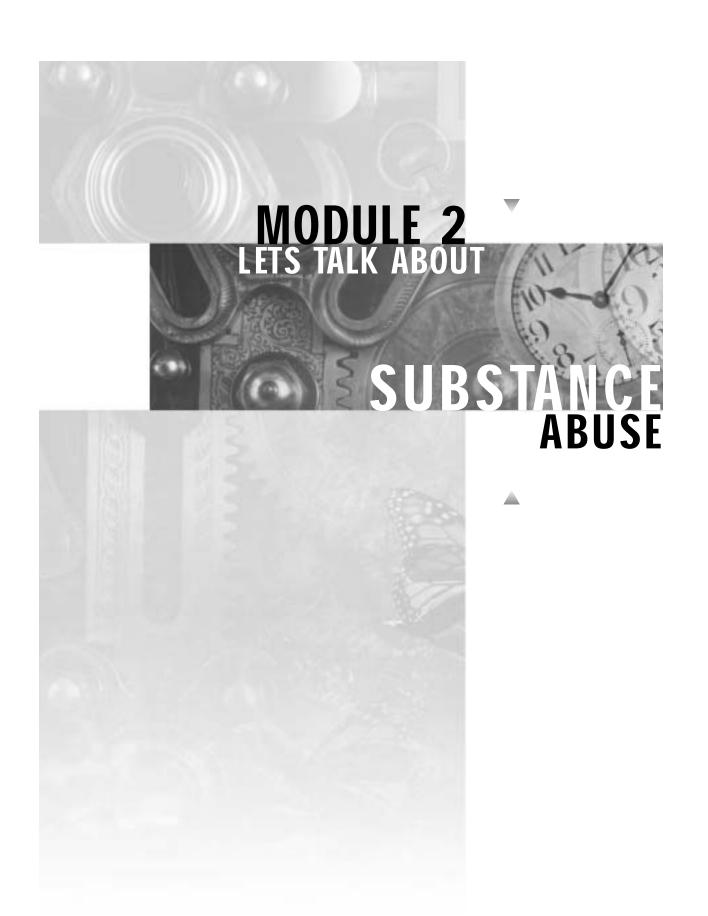
GROUND ZERO: DEFINITIONS AND FRAMEWORK

Overhead 1.9

EVOLUTION OF THE DSM

DSM - 1	Alcoholism was placed under personality disorders.
	 Addiction was a subcategory of sociopath personality disturbance.
	Addiction was considered a derangement of a person.
DSM - II	Addiction was dropped to provide a more comprehensive diagnosis
	Drug dependence replaced addiction.
	Drug dependence was placed under certain other non-psychotic mental disorders.
	Drug dependence would not require the presence of physiological addiction but "evidence of habitual use or a clear sense of need for the drug".
DSM - III	 Abuse, which implied choice and value judgements was used to describe a pattern of pathological use.
	Adoption of the word "substance" was intent to clean the nomenclature of old attitudes.
DSM - IIR	De-emphasized the importance of tolerance and dependence as criteria to diagnose addiction
	Behavioral dependence more accurately defined loss of control over drinking.
DSM - IV	Very little change from the previous edition concerning addictions.
	It does show a distinction for physiological withdrawal - with or without - physiological dependence.

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LET'S TALK ABOUT SUBSTANCE ABUSE

OVERVIEW

Since 1956, the American Medical Association has recognized and defined alcohol addiction as a <u>primary disease</u>, not a secondary symptom of an underlying psychological or medical illness. Since then, this definition has been extended to define all chemical addictions as "chronic, progressive diseases characterized by significant impairment that is directly associated with persistent and excessive use of psychoactive substances. Impairment may involve physiological, psychological, or social dysfunction."

Substance abuse disorders are among the most common and impairing of the mental disorders, as listed in the DSM-IV. This section will discuss those substances most often seen in treatment centers and that are most often combined with other mental disorders.

Time Needed	1 hour					
Methods:	Exercise (5 minutes) Lecture (30 minutes) Discussion (25) minutes)					
Goal:	To introduce participants to the disease model of addiction and to the substance abuse disorders most associated with co-occurring disorders.					
Objectives:	 By the end of module 2, participants will be able to: Define the disease model of addiction. Define substance abuse and substance dependence. List at least 3 abused substances associated with cooccurring disorders. 					
Key Points:	 Recent studies of alcoholics find that over 50% have a family history of alcoholism. The US population older than age 28 has a lifetime prevalence rate of 26.7% with a diagnosis of substance abuse or dependence. Alcohol and nicotine are the most commonly used substances in the United States. Studies have clearly established that alcoholism and drug addiction have characteristics similar to other diseases since it may be transmitted genetically. 					
Materials Needed:	Prepared newsprint and easel					

LET S TALK ABOUT SUBSTANCE ABUSE

Overhead / Notes:	 Markers Tape Notepads and pencils Overhead projector Screen Overhead transparencies Watch 2.1 Module II Objectives 2.2 Alcoholism and Drug Addiction Are Diseases 2.3 Behaviors Which Define Addiction 2.4 Most Commonly Abused Drugs By Individuals With Co-Occurring Disorders
Supplements:	2.1 Highlights2.2 DSM-IV Substance Use Disorders
Prepared Newsprints:	• None

LET'S TALK ABOUT SUBSTANCE ABUSE

Overhead 2.1

MODULE II - OBJECTIVES

• Define the disease model of addiction

Module 2: Let s Talk About Substance Abuse

- Define substance abuse and substance dependence.
- List at least three abused substances associated with co-occurring disorders.

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LET S TALK ABOUT SUBSTANCE ABUSE

Overhead 2.2

ALCOHOLISM AND DRUG ADDICTIONS ARE DISEASES!

Why?

- Have a definite specific process
- Produce characteristic and identifiable signs and symptoms, and
- · Affects multiple organ systems in the body

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LET S TALK ABOUT SUBSTANCE ABUSE

Overhead 2.3

BEHAVIORS WHICH DEFINE ADDICTION

- Preoccupation with acquisition of alcohol and/or other drugs
- Compulsive use despite adverse consequences

Module 2: Let s Talk About Substance Abuse

• Failed attempts (which establishes a pattern) to limit use despite adverse consequences

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LET S TALK ABOUT SUBSTANCE ABUSE

Overhead 2.4

DRUG OF ABUSE: USE AND EFFECT

	Drugs	Usual Methods of Administration	Possible Effects	Effects of Overdose	Withdrawal Syndrome	
Stimulants	Cocaine	Sniffed, smoked, injected	Increased alertness, excitation euphoria, increased pulse rate and blood pressure, insomnia, loss of appetite	Agitation, increased body temperature, hallucinations, convulsions, possible death	Severely depressed mood, prolonged sleep, apathy, irritability, disorientation	
	Amphetamines	Oral, injected				
	Methylphenidate					
	Other stimulants					
Depressants	Chloral hydrate	Oral	Slurred speech, disorientation,	Shallow respiration, cold and clammy skin, weak and rapid pulse, coma, possible death	Anxiety, insomnia, tremors delerium, convulsions, possible death	
	Barbiturates	Oral, injected	staggering, drunken behavior			
	Methaqualone	Oral	benavior			
	Benzodiazepines					
	Alcohol					
Opiates	Opium	Oral, smoked	Euphoria,	Slow and shallow breathing, clammy skin, constricted pupils, coma, possible death	Watery eyes, runny nose, yawning, loss of appetite,	
	Morphine	Oral, injected	drowsiness, slowed			
	Codeine	Oral	respiration, nausea			
	Heroin				tremors, panic,	
	Methadone	Injected, smoked			chills and sweating,	
	Other opiates	Oral, injected			cramps, nausea	
Cannibis	Marijuana	Smoked	Eurphoria, relaxed inhibitions, increased appetite, impaired memory and attention	Fatigue, paranoia, at very high doses a hallucinogen-like psychotic state	Insomnia hyperactivity (syndrome is rare)	
	Hashish	Smoked				

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LET S TALK ABOUT SUBSTANCE ABUSE

Supplement 2.1

HIGHLIGHTS

This report is the first release of information from the 1999 National Household Survey on Drug Abuse (NHSDA), a project of the Substance Abuse and Mental Health Services Administration (SAMHSA). Since 1971, the NHSDA has been the primary source of information on the prevalence and incidence of illicit drug, alcohol, and tobacco use in the civilian population age 12 years and older.

Over the years improvements were made to the Household Survey to provide better and more complete information from the public. In 1999 another major improvement was made to the survey. The sample size was expanded almost fourfold from previous years and data are now based on information obtained from nearly 70,000 persons. The sample design was also changed. Previous samples were designed to produce only national estimates. The new sample design supports the development of both national and state estimates of substance use. A new, interactive, bilingual, computerbased questionnaire was introduced. Earlier surveys relied on paper and pencil questionnaires for the respondent to complete. All these changes were designed to improve the accuracy of the survey. At the same time the changes limit the comparisons that can be made with information obtained from surveys prior to 1999. To provide a basis for analyzing trends in substance use prevalence given the major changes in the 1999 survey and the importance of documenting trends, a supplemental sample of 13,000 individuals was interviewed using the paper and pencil technique employed in previous years of the Household Survey. The supplemental survey design produced, for a limited set of measures, estimates that are comparable to previous surveys but are slightly different from those generated from the 1999 expanded computer-based survey. While each estimate is a valid scientific measure of prevalence based on the survey method used, the supplemental survey findings are most useful for making appropriate comparisons with earlier data and to identify trends in prevalence. The computer-based expanded sample estimates are used for the analysis of national patterns of substance use and demographic differences in 1999, trends in new users, and the State estimates.

This report provides national estimates of rates of use, number of users, and other measures related to use of illicit drugs, alcohol, cigarettes, and other forms of tobacco by the population, ages 12 years and older. It includes national estimates of trends in the initiation of substance use, as well as the extent of both drug dependence and drug treatment in the country. Perhaps the most important new data produced by the expanded Household Survey are the State-by-State estimates of substance use

LET S TALK ABOUT SUBSTANCE ABUSE

prevalence. For the first time ever, the report provides estimates of illicit drug, alcohol, and cigarette use by age group that can be compared across States and the District of Columbia. These new data can help inform policymakers at the Federal, State and local levels about the unique prevention and treatment needs of States. The information on the problems of substance abuse in the States will be greatly expanded in other reports that will be published in Fall, 2000.

NATIONAL ESTIMATES

Illicit Drug Use

- An estimated 14.8 million Americans were current users of illicit drugs in 1999, meaning they used an illicit drug at least once during the 30 days prior to the interview. By comparison, the number of current illicit drug users was at its highest level in 1979 when the estimate was 25 million.
- 10.9 percent of youths age 12-17 reported current use of illicit drugs in 1999. Marijuana is the major illicit drug used by this group; 7.7 percent of youths were current users of marijuana in 1999.
- Among youths age 12-17, the percent using illicit drugs in the 30 days prior to interview was slightly higher for boys (11.3 percent) than for girls (10.5 percent). Although in the age group 12-17 years boys had a slightly higher rate of marijuana use than girls (8.4 percent vs. 7.1 percent), girls were somewhat more likely to use psychotherapeutics nonmedically than boys (3.2 percent vs. 2.6 percent).
- The rates of current illicit drug use for major racial/ethnic groups were 6.6 percent for whites, 6.8 percent for Hispanics, and 7.7 percent for blacks. The rate was highest among the American Indian/Alaska Native population (10.6 percent) and among persons reporting multiple race (11.2 percent). Asians had the lowest rate (3.2 percent).
- The rate of illicit drug use in metropolitan areas was higher than the rate in non-metropolitan areas. Rates were 7.1 percent in large metropolitan areas, 7.0 percent in small metropolitan areas, and 5.2 percent in nonmetropolitan areas. Rural non-metropolitan counties had a lower rate of illicit drug use (4.2 percent) than other counties.

LET S TALK ABOUT SUBSTANCE ABUSE

Tobacco Use

- An estimated 66.8 million Americans reported current use of a tobacco product in 1999, a prevalence rate of 30.2 percent for the population 12 and older. Of this total, 57.0 million (25.8 percent) smoked cigarettes, 12.1 million (5.5 percent) smoked cigars, 7.6 million (3.4 percent) used smokeless tobacco, and 2.4 million (1.1 percent) smoked tobacco in pipes.
- Current cigarette smoking rates increase steadily by year of age, from 2.2
 percent at age 12 to 43.5 percent at age 20. Overall, 14.9 percent of youths age
 12 to 17 years in 1999 smoked cigarettes currently. Among young adults age 18
 to 25 years, the rate was 39.7 percent, and among adults age 26 and older the
 rate was 24.9 percent.
- Three brands account for most of adolescent cigarette smoking. 54.5 percent of current smokers 12 to 17 years of age report Marlboro as their usual brand. Newport was reported by 21.6 percent of youth smokers, and Camel was reported by 9.8 percent. No other cigarettebrand was reported by even 2 percent of youths.
- Race/ethnicity differences in usual cigarette brand used were evident among both adult and youth (age 12-17 years) smokers. More than half of white (58.4 percent) and Hispanic (59.7 percent) youth smokers reported Marlboro as their usual brand. About three quarters (73.9 percent) of black adolescent smokers reported Newport as their usual brand.
- Youths age 12-17 who currently smoked cigarettes were seven times more likely to use illicit drugs than youths who didn't smoke. Young adults age 18 to 25 who smoked were four times more likely to use illicit drugs than their nonsmoking peers.

Alcohol Use

- In 1999, 105 million Americans age 12 and older reported current use of alcohol, meaning they used alcohol at least once during the 30 days prior to the interview. About 45 million of this group engaged in binge drinking, meaning they drank 5 or more drinks on one occasion during that 30 day period. 12.4 million were heavy drinkers, meaning they had 5 or more drinks on one occasion 5 or more days during the past 30 days.
- Although consumption of alcoholic beverages is illegal for those under 21 years

LET S TALK ABOUT SUBSTANCE ABUSE

of age, 10.4 million current drinkers were age 12-20 in 1999. Of this group, 6.8 million engaged in binge drinking, including 2.1 million who would also be classified as heavy drinkers.

 For current alcohol use, binge drinking, and heavy alcohol use, 21 is the age of peak prevalence

Trends in Substance Use Prevalence

Because of the differences in methodology and impact of the new survey design on data collection, only limited comparisons can be made between data from the 1999 survey and data from surveys prior to 1999. These comparisons are made based on data from a separate supplemental sample of 13,000 respondents in 1999 that responded using the paper questionnaire used in prior surveys. Thus, 1999 estimates discussed below are different from 1999 estimates discussed elsewhere. Trend data from the Household Survey are presented in a way to recognize important shifts in attitudes and behavior that are statistically significant.

- There were no significant changes in the rate of past month illicit drug use in any of the age groups 12-17 years, 18-25 years, 26-34 years, or 35 years and older between 1998 and 1999. However, the rate of use was lower in 1999 than in 1997 for the age group 12-17 years, and there appears to be a consistent downward trend (11.4 percent in 1997, 9.9 percent in 1998, 9.0 percent in 1999). Among young adults age 18 to 25 years, the rate increased between 1997 and 1999 (14.7 percent in 1997, 16.1 percent in 1998, and 18.8 percent in 1999). The rates for the age group 26-34 years old and 35 years and older in 1999 have not changed significantly since 1994.
- Trends for marijuana use were similar to the trends for any illicit use. There were no significant changes between 1998 and 1999 for any of the four age groups, but an increasing trend since 1997 among young adults age 18-25 years (12.8 percent in 1997, 13.8 percent in 1998, and 16.4 percent in 1999) and a decreasing trend since 1997 for youths age 12-17 years (9.4 percent in 1997, 8.3 percent in 1998, and 7.0 percent in 1999).
- The rate of current cigarette use in the population age 12 and older was similar in 1999 (29.7 percent) to the rates estimated from 1994 through 1998. Among youths age 12-17, the rate was 15.9 percent in 1999, not statistically different than in 1998 (18.2 percent) but significantly lower than the rate in 1997 (19.9 percent).

LET S TALK ABOUT SUBSTANCE ABUSE

- Rates of current alcohol, binge alcohol, and heavy alcohol use remained unchanged from 1998 to 1999, for all ages 12 and older; and the same was true for each age group, continuing a level trend seen throughout the 1990s.
- The percentage of youths age 12-17 years reporting great risk of harm in using cocaine once a month decreased between 1998 and 1999, from 54.3 percent to 49.8 percent. This is down from the estimate of 63.3 percent in 1994.
- Although there were no significant changes among youth age 12 to 17 years in perceived risk of marijuana use between 1998 and 1999, the percentages were down somewhat. More important, the perceptions of risk were significantly lower than in 1996. The percent of youths who reported great risk in smoking marijuana once a month was 32.6 percent in 1996, 30.9 percent in 1997, 30.8 percent in 1998, and 29.0 percent in 1999. For smoking marijuana once or twice a week, percentages for those years were 57.1, 54.0, 54.4, and 52.6 percent, respectively.

Trends in New Use of Substances (Incidence)

Trends in new use of substances are estimated using the data reported on age at first use from the computer-administered 1999 NHSDA. Because information on when people first used a substance is collected on a retrospective basis, information on first time use or incidence is always one year behind information on current use. Trend data from the Household Survey are presented in a way to recognize important shifts in attitudes and behavior that are statistically significant.

- An estimated 2.3 million persons first used marijuana in 1998. This translates to about 6,400 new marijuana users per day. More than two-thirds of these new users were under age 18. The rates of marijuana initiation for youth during 1995 through 1998 are at their highest levels since the peak levels in the late 1970s. The rate had increased between 1991 and 1995 from 46 per thousand potential new users in 1991 to 80 per thousand potential new users in 1995; that is, use of marijuana by youths who had never previously used the substance doubled during that time period. However, the 1998 rate for youth (81.0) was significantly lower than the 1997rate (90.8).
- There were an estimated 149,000 new heroin users in 1998, not statistically different than the 189,000 new users in 1997 or the 132,000 new users in 1996. Estimates of heroin incidence are subject to wide variability and usually do not show any clear trend.

LET S TALK ABOUT SUBSTANCE ABUSE

- A large proportion of the recent heroin initiates are young and are smoking, sniffing, or snorting heroin. Among the estimated 471,000 persons who used heroin for the first time during 1996 through 1998, a quarter (125,000) were under age 18 and another 47 percent (222,000) were age 18 to 25 at the time of first use. Only 37 percent reported having ever injected heroin by 1999. Most (89 percent) were living in metropolitan areas.
- An estimated 1.6 million Americans used prescription-type pain relievers nonmedically for the first time in 1998. This represents a significant increase since the 1980s, when there were generally fewer than 500,000 initiates per year. Among youths age 12-17, the incidence rate increased from 6.3 per 1,000 potential new users in 1990 to 32.4 per 1,000 potential new users in 1998. For young adults age 18-25, there was also an increase in the rate of first use between 1990 and 1998 (from 7.7 to 20.3 per 1,000 potential new users).
- An estimated 1.6 million people began smoking cigarettes daily in 1998. About half of these new smokers were younger than age 18. This translates to more than 4,000 new regular smokers per day, of which more than 2,000 are youths.
- An estimated 4.9 million people tried cigars for the first time in 1998, about 13,000 per day. This represents a threefold increase in cigar initiation since 1991, when there were only 1.5 million new cigar smokers. The average age of cigar initiates has changed little since the 1980s, and incidence rates have increased among both youths (from 21.4 in 1991 to 97.6 in 1998) and young adults (from 27.1 in 1991 to 89.0 in 1998).

Prevention-Related Data

- In 1999, 37.2 percent of youth believed that there was a great risk of harm if they smoked marijuana once a month. Those reporting a moderate or great risk had a past month prevalence rate of marijuana use of only 3.1 percent, while those reporting they believed there was no risk or only a slight risk had a rate of 18.5 percent.
- 56.5 percent of youths age 12-17 reported marijuana was easy to obtain in 1999.
 15.6 percent of youths reported being approached by someone selling drugs during the 30 days prior to the interview.
- 6.5 percent of youth said that their parents would neither approve or disapprove if

LET S TALK ABOUT SUBSTANCE ABUSE

they smoked one or more packs of cigarettes a day, while 87.4 percent thought their parents would strongly disapprove. Those youth who thought their parents would neither approve nor disapprove weremore likely to have used marijuana in the past month (19.6 percent) compared to those whose parents would strongly disapprove (about 5.7 percent).

Substance Dependence and Treatment

- In 1999 an estimated 3.6 million Americans (1.6 percent of the total population age 12 and older) were dependent on illicit drugs. An estimated 8.2 million Americans were dependent on alcohol (3.7 percent). Of these, 1.5 million people were dependent on both. Overall, an estimated 10.3 million people were dependent on either alcohol or illicit drugs (4.7 percent).
- Adults who had first used drugs at a young age were more likely to be dependent on drugs than adults who initiated use at a later age. Among adults who had first tried marijuana at age 14 or younger, 8.9 percent were dependent on an illicit drug in the past year, compared with only 1.7 percent of adults who had first tried marijuana at age 18 or older.
- Males were more likely to be dependent on illicit drugs than females. In 1999, 2.0 percent of males (ages 12 and older) were dependent on illicit drugs compared to 1.3 percent of females. Males were also more likely to be dependent on alcohol (4.9 percent compared to 2.6 percent). However, for the youngest age group, 12-17, the percent dependent on illicit drugs was the same for males and females (3.3 percent for both). The rate for adolescent males and females was also essentially the same for alcohol (3.3 percent for males and 3.9 percent for females).

State Estimates

Estimates of substance use for all 50 states and the District of Columbia were developed using a small area estimation model that combines sample data from each state with a national regression model that includes local indicators related to substance use.

• Of the ten states with the highest rates of current illicit drug use in the population age 12 and older, six were in the West region. Eight of the ten states with the lowest rates were in the South region. However, within the regions, there was considerable variation. For example, Utah, a Western state, had a relatively low past month prevalence rate of 6.2 percent. Delaware, a Southern state, had one

LET S TALK ABOUT SUBSTANCE ABUSE

of the higher rates in the country (8.5 percent). Prevalence estimates ranged from a low of 4.7 percent (Virginia) to a high of 10.7 percent (Alaska).

- Six of the 10 states that were in the highest ranking category for past month use of any illicit drug for persons age 12 and older were also in the highest group for youth ages 12 to 17. The rate for youth was lowest for the state of Utah (8.0 percent). The highest estimate for youth was in Delaware (18.3 percent).
- The state with the highest rate of binge drinking for persons age 12 and older was North Dakota(28.7 percent). Most of the states with high rates were northern states. Seven out of the top 10 states were in the Midwest region. The state with the lowest rate was Maryland at 15.3 percent. Most of the states with the lowest rates of binge drinking were Southern states.
- A number of the states which rank in the top ten for past month cigarette use were not in the top 10 for illicit drug use or binge alcohol use. Those states include Kentucky, West Virginia, Ohio, Oklahoma, North Carolina, and Indiana.
- For cigarette use, five states ranked in the top ten for both youth age 12-17 and for all ages 12 and older. These states were Kentucky, West Virginia, Minnesota, Delaware, and North Carolina.
- The state with the highest rates of past year dependence on illicit drugs and on
 illicit drugs or alcohol was Alaska with 2.8 percent of its 12 and older population
 dependent on illicit drugs and 7.3 percent dependent on illicit drugs or alcohol.
 Six of the ten states with the highest rates of dependence on any illicit drug or
 alcohol were Western states and three were Midwestern states.

MODULE 2:

LET S TALK ABOUT SUBSTANCE ABUSE

Supplement 2.2

DSM-IV SUBSTANCE USE DISORDERS

The Diagnostic and Statistical Manual, Fourth Edition (DSM-IV) is the set of criteria for psychiatric disorder adopted by the American Psychiatric Association. It includes the following general sets of criteria with more specific criteria for particular substances.

Criteria for Substance Dependence

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

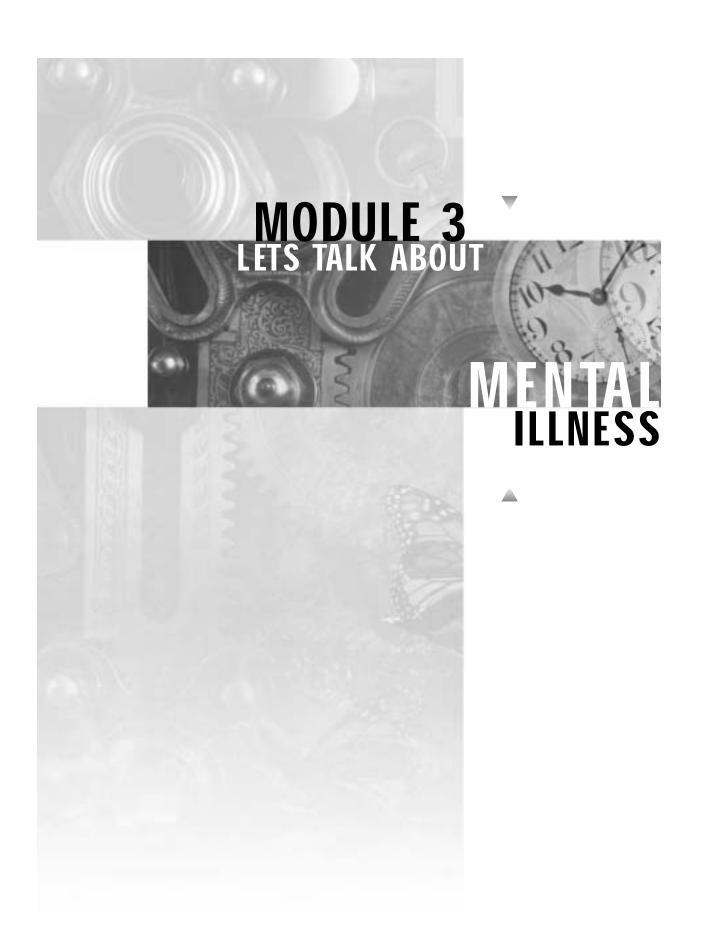
- 1. tolerance, as defined by either of the following:
 - a. a need for markedly increased amounts of the substance to achieve intoxication or desired effect
 - b. markedly diminished effect with continued use of the same amount of the substance
- 2. withdrawal, as manifested by either of the following:
 - a. the characteristic withdrawal syndrome for the substance (refer to Criteria A and B of the criteria sets for withdrawal from the specific substances)
 - b. the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms
- 3. the substance is often taken in larger amounts or over a longer period than was intended
- 4. there is a persistent desire or unsuccessful efforts to cut down or control substance use
- 5. a great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance (e.g., chain-smoking), or recover from its effects
- 6. important social, occupational, or recreational activities are given up or reduced because of substance use
- 7. the substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption)

MODULE 2:

LET S TALK ABOUT SUBSTANCE ABUSE

Criteria for Substance Abuse

- A. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:
 - recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household)
 - 2. recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use)
 - 3. recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct)
 - continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights)
- B. The symptoms have never met the criteria for Substance Dependence for this class of substance



ET S TALK ABOUT. MENTAL ILLNESS

OVERVIEW

Mental illness is an illness that affects or is manifested in a person's brain. It may impact on the way a person thinks, behaves, and interacts with other people. The term "mental illness" actually encompasses numerous psychiatric disorders, and just like illnesses that affect other parts of the body, they can vary in severity. It is a myth that mental illness is a weakness or defect in character and that sufferers can get better simply by "pulling themselves up by their bootstraps." Mental illnesses are real illnesses—as real as heart disease and cancer—and they require and respond well to treatment.

The term "mental illness" is an unfortunate one because it implies a distinction between "mental" disorders and "physical" disorders. Research shows that there is much "physical" in "mental" disorders and vice-versa. For example, the brain chemistry of a person with major depression is different from that of a nondepressed person, and medication can be used (often in combination with psychotherapy) to bring the brain chemistry back to normal. Similarly, a person who is suffering from hardening of the arteries in the brain—which reduces the flow of blood and thus oxygen in the brain—may experience such "mental" symptoms as confusion and forgetfulness.

Time Needed	1 hour
Methods:	Lecture (25 minutes) Discussion (30 minutes) Exercise (5 minutes)
Goal:	To provide participants with the basics involved in working with individuals who have a mental illness.
Objectives:	 By the end of module 3, participants will be able to: Define mental illness. List at least 3 warning signs of mental illness in adults; and Identify the mental disorders most associated with co-occurrence.
Key Points:	 Mental illness is an illness that affects or is manifested in a person's brain. The term "mental illness" actually encompasses numerous psychiatric disorders, and just like illnesses that affect other parts of the body, they can vary in severity.

LET S TALK ABOUT MENTAL ILLNESS

	• Over 200	recognized mental illnesses are described		
	 Over 200 recognized mental illnesses are described and categorized in the book Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. 			
Materials Needed:	MarkersTapeNotepadsOverheadScreen	newsprint and easel and pencils projector transparencies		
Overhead / Notes:	3.13.2a32b3.33.4	Module III Objectives Definition of Mental Disorder Definition of Mental Disorder (cont'd) Warning Signs of Mental Illness in Adults Mental Disorders Most Associated With Co-Occurrence		
Supplements:	3.13.23.3	What Is Mental Illness? Statistics On The Prevalence Of Mental Illness Mental Disorders Most Associated With Co-Occurrence		
Prepared Newsprints:	None			

LET S TALK ABOUT MENTAL ILLNESS

Overhead 3.1

MODULE III - OBJECTIVES

• Define mental illness,

Module 3: Let s Talk About Mental Illness

- List at least three warning signs of mental illness in adults; and
- Identify the mental disorders most associated with co-occurrence.

NOTES	 	 	

LET S TALK ABOUT MENTAL ILLNESS

Overhead 3.2a

MENTAL DISORDER

- Is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress or disability or with a significantly increased risk of suffering, death, pain, disability, or an important loss of freedom.
- This syndrome or pattern must NOT be merely an expectable and culturally sanctioned response to a particular event

NOTES		 	

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Module 3: Let s Talk About Mental Illness

LET S TALK ABOUT MENTAL ILLNESS

Overhead 3.2b

MENTAL DISORDER (cont)

- Regardless its original cause, it must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the individual.
- Neither deviant behavior (e.g., political, religious, or sexual) nor conflicts that are
 primarily between the individual and society are mental disorders unless the
 deviance or conflict is a symptom of a dysfunction in the individual, as described
 above

NOTES	 		

LET S TALK ABOUT MENTAL ILLNESS

Overhead 3.3

WARNING SIGNS OF MENTAL ILLNESS IN ADULTS

- · Confused thinking
- Prolonged depression (sadness or irritability)
- Feelings of extreme highs and lows
- Excessive fears, worries and anxieties
- Social withdrawal
- Dramatic changes in eating or sleeping habits
- Strong feelings of anger
- Delusions or hallucinations
- . Growing inability to cope with daily problems and activities
- · Suicidal thoughts
- Denial of obvious problems
- Numerous unexplained physical ailments

NOTES	 	 	 	

LET S TALK ABOUT MENTAL ILLNESS

Overhead 3.4

MENTAL DISORDERS MOST ASSOCIATED WITH CO-OCCURRENCE

- Anxiety Disorders
- Mood Disorders
- Psychotic Disorders
- Dissociative Disorders
- Eating Disorders
- Impulse-Control Disorders
- Disorders First Diagnosed in Infancy Childhood, or Adolescence
- Personality Disorders

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ET S TALK ABOUT MENTAL ILLNESS

Supplement 3.1

What Is Mental Illness?

A **mental illness** is a disease that causes mild to severe disturbances in thought and/or behavior, resulting in an inability to cope with life's ordinary demands and routines. Mental health problems may be related to excessive stress due to a particular situation or series of events. As with cancer, diabetes and heart disease, mental illnesses are often physical as well as emotional and psychological. Feeling environmental stresses, genetic factors, biochemical imbalances, or a combination of these may cause mental illnesses. With proper care and treatment many individuals learn to cope or recover from a mental illness or emotional disorder. For others, it may be a lifelong challenge.

There are more than 200 classified forms of mental illnesses. Some of the more common disorders are depression, bipolar disorders, dementia, schizophrenia and anxiety disorders. Symptoms may include changes in mood, personality, personal habits and/or social withdrawal.

Warning Signs Of Mental Illness In Adults Include:

- confused thinking
- prolonged depression (sadness or irritability)
- feelings of extreme highs and lows
- excessive fears, worries and anxieties
- social withdrawal
- dramatic changes in eating or sleeping habits
- strong feelings of anger
- delusions or hallucinations
- growing inability to cope with daily problems and activities
- suicidal thoughts
- denial of obvious problems
- numerous unexplained physical ailments
- substance abuse

Mental illnesses are treatable, and the cost of not treating them may be high, both in personal and financial terms. An untreated illness can disrupt an individual's personal,

LET S TALK ABOUT MENTAL ILLNESS

social, educational and work activities and, in some cases, may lead to suicide. The economic costs of mental illnesses are significant as well: recent figures indicate that the indirect cost of mental illnesses in the U.S. (due primarily to lost productivity and early morbidity) exceeds \$72 billion. The National Institute of Mental Health estimates that one in five people will experience mental illness in their lifetimes and one in four of us knows someone personally who has a mental illness. Anxiety disorders are the most common, affecting nearly 15% of people at some time in their lives. Depressive disorders occur nearly 8% in our lifetimes, while 2% of people will experience schizophrenia in their lifetimes.

LET S TALK ABOUT MENTAL ILLNESS

Supplement 3.2

Statistics On The Prevalence Of Mental Health

- More than 51 million Americans have a mental disorder in single year, although only about 8 million (16 percent) seek treatment. (NIMH & CMHS, 1994)
- During the course of any given year, while more than 40 million adult Americans are affected by one or more mental disorders, 6.5 million Americans are disabled by severe mental illnesses. (NIMH, 1990)
- Studies indicate that 1 in 5 children and adolescents (20 percent) may have a
 diagnosable disorder. Estimates of the number of children who have mental disorders
 range from 7.7 million to 12.8 million. (CMHS, 1993). These youth are estimated to
 have severe emotional or behavioral problems that significantly interfere with their daily
 functioning.
- Less than one-third of the children under age 18 with a serious emotional disturbance receive mental health services. Often, the services are inappropriate. (Children's Defense Fund) (CMHS-Mental Health, U.S., 1994)
- An estimated 19.9 million Americans-8.8 percent of the population experience phobias. About 9.1 million-5.1 percent live with major depression. Some 3.9 million have obsessive compulsive disorder; 2.0 million have schizophrenia; 2.4 million have panic disorder; and 2.0 million experience bipolar disorders. (NMHA, 1993), (Mental Health, U.S., 1994)
- As least two thirds of elderly nursing home residents have a diagnosis of a mental disorder such as major depression. (NIMH, 1990)
- Up to 25 percent of the population with AIDS will develop AIDS-related cognitive dysfunction. Two-thirds of all people with AIDS will develop neuropsychiatric problems. (Mental Health Liaison Group, 1993)
- A majority of the 29,000 Americans who commit suicide each year are believed to have a mental disorder. Suicide is the eighth leading cause of death in the U.S. and the third leading cause of death among people aged 15 to 24. (NIMH, 1994)
- Nearly one-third of the nation's estimated 600,000 homeless Individuals are believed to be severely mentally ill adults. (CMHS, 1992)
- More than 1 in 14 jail Inmates has a mental illness. Twenty-nine percent of the nation's jails routinely hold people with mental illnesses without any criminal charges. (National Alliance for the Mentally III and Public Citizens Health Research Group, 1992)

LET S TALK ABOUT MENTAL ILLNESS

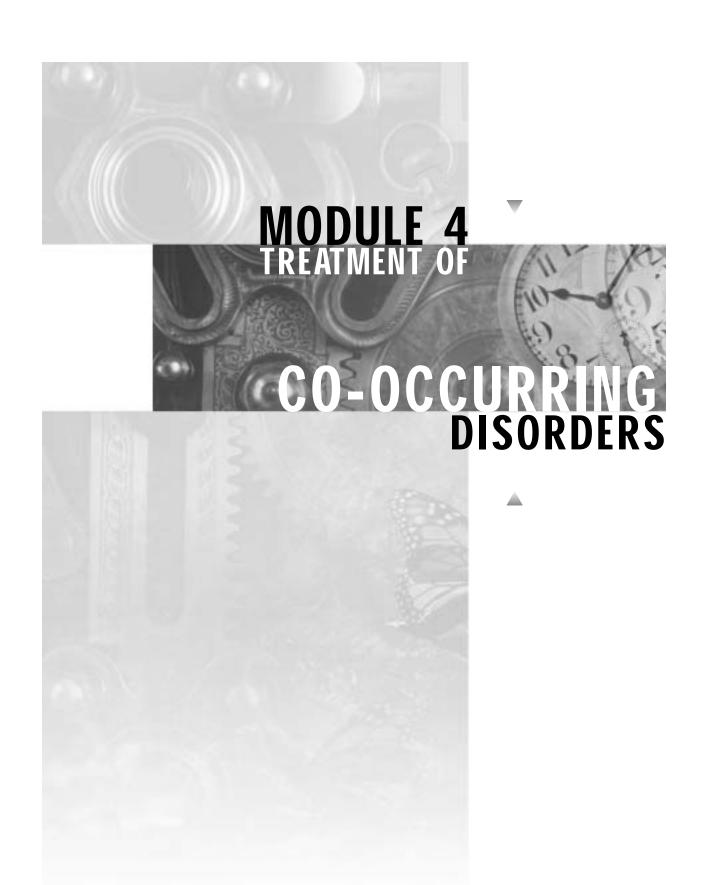
Supplement 3.3

The following psychiatric problems are common to occur in dual diagnosis - *i.e.*, *in tandem with alcohol or drug dependency*.

- Depressive disorders, such as depression and bipolar disorder.
- **Anxiety disorders,** including generalized anxiety disorder, panic disorder, obsessive-compulsive disorder, and phobias.
- Other psychiatric disorders, such as schizophrenia and personality disorders

Based on a National Institute of Mental Health study, the following table lists seven major psychiatric disorders and illustrates how much each one increases an individual's risk for substance abuse.

Psychiatric Disorder	Increased Risk For Substance Abuse
Antisocial personality disorder	15.5%
Manic episode	14.5
Schizophrenia	10.1
Panic disorder	4.3
Major depressive episode	4.1
Obsessive-compulsive disorder	3.4
Phobias	2.4



TREATMENT OF

CO-OCCURRING DISORDERS

OVERVIEW

Persons diagnosed with co-occurring disorders present unique challenges for existing treatment systems. Optimal care will require some simple modifications to traditional protocols of assessment, treatment, and follow-up commonly used by providers of substance abuse and mental health services.

Time Needed	1 hour and 15 minutes
Methods:	Lecture (40 minutes) Discussion (20 minutes) Exercise (15) minutes)
Goal:	To orient participants to the significant elements of treatment for co-occurring disorders.
Objectives:	 By the end of module 4, participants will be able to: Differentiate the concepts of sequential, parallel, and integrated treatment. Recognize general elements of integrated treatment that span treatment contexts. Identify methods to improve individual approaches to assessment and treatment of co-occurring disorders.
Key Points:	 Integrated treatment is a philosophy of care that can be provided in a variety of different contexts given appropriate resources and staffing. Comprehensive assessment of mental illness and substance use plays a critical role in determining appropriate level of care. Severity of substance abuse and mental illness can vary independently and has implications for treatment placement. Regardless of setting, treatment of co-occurring disorders incorporates a common set of core strategies. Motivational interviewing/enhancement is a particularly useful treatment paradigm for use with co-occurring disorders. Specific interventions may be tailored to predictable phases of recovery.

TREATMENT OF CO-OCCURRING DISORDERS

Materials Needed:	 Prepared newsprints and easel Markers Tape Notepads and pencils Overhead projector Screen
	Overhead transparenciesWatch
Overheads / Notes:	
Overnieads / Notes.	 4.1 Parallels: Addiction and Psychiatric Illness 4.2 Treatment Models for Co-Occurring Disorders 4.3 Severity of Mental Health and Substance Use Disorders 4.4 Assessment and Placement: Example from ASAM PPC2 4.5 General Treatment Elements 4.6 Stages of Treatment #1: Acute Stabilization 4.7 Stages of Treatment #2: Engagement/Persuasion 4.8 Stages of Treatment #3: Active Treatment/Relapse Prevention 4.9 Stages of Treatment #4: Recovery/Rehabilitation
Supplements:	 4.1 Mental Illness or Substance Abuse??? 4.2 Treatment Models 4.3 Severity of Mental Health and Substance Abuse Disorders 4.4 Assessment and Placement Strategies 4.5 General Treatment Elements 4.6 Stages of Recovery and Treatment Strategies
Prepared Newsprints:	NONE

TREATMENT OF CO-OCCURRING DISORDERS

Overhead 4.1

PARALLELLS: ADDICTION AND PSYCHIATRIC ILLNESS

ALCOHOLISM/ADDICTION **MAJOR MENTAL ILLNESS**

- A BIOLOGICAL ILLNESS
- HEREDITARY (IN PART)
- 3. CHRONICITY
- **INCURABILITY** 4.
- LEADS TO LACK OF CONTROL OF BEHAVIOR AND EMOTIONS
- POSITIVE AND NEGATIVE **SYMPTOMS**
- 7. AFFECTS THE WHOLE FAMILY
- PROGRESSION OF THE DISEASE WITHOUT TREATMENT
- SYMPTOMS CAN BE CONTROLLED WITH PROPER TREATMENT
- 10. DISEASE OF DENIAL
- 11. FACING THE DISEASE CAN LEAD TO DEPRESSION AND DESPAIR
- 12. DISEASE IS OFTEN SEEN AS A "MORAL ISSUE" DUE TO PERSONAL WEAKNESS RATHER THAN BIOLOGICAL CAUSES
- 13. FEELINGS OF GUILT AND FAILUR 13. FEELINGS OF GUILT AND
- 14. FEELINGS OF SHAME AND **STIGMA**
- PHYSICAL, MENTAL, AND SPIRITUAL DISEASE

- A BIOLOGICAL ILLNESS
- HEREDITARY (IN PART)
- CHRONICITY 3.
- **INCURABILITY** 4.
- LEADS TO LACK OF CONTROL OF BEHAVIOR AND AND EMOTIONS
- POSITIVE AND NEGATIVE **SYMPTOMS**
- 7. AFFECTS THE WHOLE FAMILY
- PROGRESSION OF THE **DISEASE WITHOUT TREATMENT**
- SYMPTOMS CAN BE CONTROLLED WITH PROPER TREATMENT
- 10. DISEASE OF DENIAL
- 11. FACING THE DISEASE CAN LEAD TO DEPRESSION AND **DESPAIR**
- 12. DISEASE IS OFTEN SEEN AS A "MORAL ISSUE" DUE TO PERSONAL WEAKNESS RATHER THAN BIOLOGICAL **CAUSES**
- **FAILURE**
- 14. FEELINGS OF SHAME AND STIGMA
- 15. PHYSICAL, MENTAL, AND SPIRITUAL DISEASE

IOTES	 	 	

CO-OCCURRING DISORDERS

Overhead 4.2

TREATMENT MODELS FOR CO-OCCURRING DISORDERS

Sequential -

- First and historically most common model used
- · Patient is treated by one system at a time
- · Patients frequently receive conflicting messages

Parallel -

- · Simultaneous treatment provided by mental health and addiction treatment settings
- Utilizes existing treatment programs and settings
- Coordination of services between settings varies widely
- · Patients frequently receive conflicting messages

Integrated -

- · Combines elements of both mental health and addiction treatment into a unified and comprehensive treatment program for the patient
- Both disorders treated as primary
- Patient receives simultaneous treatment of both disorders in a setting designed to accommodate both problems
- Clinicians have typically received specialized training in dual disorders
- Patient no longer shoulders responsibility for integrating their care

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TREATMENT OF CO-OCCURRING DISORDERS

Overhead 4.3

SEVERITY OF MENTAL HEALTH AND SUBSTANCE ABUSE DISORDERS

Ш I۷ **Less Severe Mental More Severe Mental** Disorder/ Disorder/ **More Severe Substance More Severe Substance Abuse Disorder Abuse Disorder** Substance Abuse Ш I۷ **Less Severe Mental More Severe Mental** Disorder/ Disorder/ **Less Severe Substance Less Severe Substance Abuse Disorder Abuse Disorder Mental Health** Severity

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TREATMENT OF CO-OCCURRING DISORDERS

Overhead 4.4

ASSESSMENT AND PLACEMENT: EXAMPLE FROM ASAM PPC2

Level IV Assessment Variables **Patient Preference Medically Managed** Diagnosis Intensive Inpatient Course of Illness General characteristics that Primary medical and nursing **Prior Treatment Response** form the first level of data for services/full hospital resources **Family History** input to decisions rules Level III Mental Status Medically Managed Intensive Inpatient Planned regimen of 24-hour observation, treatment Intoxication/Withdrawal **Matching Variables Biomedical Conditions** Specific data elements **Psychological Conditions** that are required for **Treatment Readiness** Level II multidimensional Relapse Potential matching to a discreet level of care **Environmental Status** Intensive Outpatient/ Partial Hospitalization Programmatic therapeutic milieu/9 hours/week minimum **Modifying Variables** Age Gender Modifiers in determining Level I **Sexual Orientation** level of care based on intervening factors that Culture/Language/Ethnicity Service Availability/Access exist within the patient or **Outpatient Treatment** Childcare/Eldercare treatment program Nonresidential/fewer than 9 hours/week **Patient Preference**

NOTES	 	 	

CO-OCCURRING DISORD

Overhead 4.5

GENERAL TREATMENT ELEMENTS

- Staff must be cross-trained in the treatment of co-occurring disorders.
- · Motivational enhancement concepts are used as a basis for treatment philosophy.
- Treatments must be appropriate and sensitive across culture, ethnicity, and gender.
- · Treatment programs must take a long-term perspective that provides appropriate assessment and treatment across all phases of recovery and relapse.
- A strong therapeutic alliance fosters patient engagement in the treatment process, consistency in treatment, and positive treatment outcomes.
- Group-based interventions are a key method of enhancing recovery activities, providing an ideal forum for peer support, psychoeducation, and self-help activities.
- · Case management is used to attend to the range of clinical, housing, social, or other needs by providing services directly in the community.
- Staff must possess and communicate optimism regarding patients' opportunity for recovery in an integrated environment.

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TREATMENT OF CO-OCCURRING DISORDERS

Overhead 4.6

STAGES OF TREATMENT #1: ACUTE STABILIZATION

Treatment options vary in intensity based on severity of psychiatric and substancerelated decompensation. Integrated care may be provided within a variety of contexts, including:

- Inpatient hospitalization
- Detoxification program
- Substance-capable crisis bed

In all cases, appropriate psychotropic medication should be maintained to address psychiatric symptoms.

TES	 	 	

CO-OCCURRING DISORD

Overhead 4.7

STAGES OF TREATMENT #2: ENGAGEMENT/PERSUASION

Engagement techniques are similar across all dual disorder subtypes and consistent with the philosophy of motivational interviewing. The objective is to prepare a patient for active treatment.

Principals of Motivational Interviewing:

- Establish empathy and validate ambivalence
- · Increase cognitive dissonance by reframing
- · Don't argue
- Don't label
- Reframe when you encounter resistance ("roll with resistance")
- · Build self-efficacy through optimism and collaborative problem-solving

Motivational interviewing techniques are commonly associated with a philosophical model of behavior change developed by Prochaska and DiClemente (1983). Their transtheoretical model of behavior change posits that individuals pass through 5 stages in the process of behavior change. Motivational interviewing techniques focus on tailoring the intervention to where a person stands in the process of change.

Five Stages of Behavior Change:

- Precontemplation
- Contemplation
- Preparation
- Action
- Maintenance

These principles are often preferred in treatment of co-occurring disorders because they facilitate greater engagement and increased treatment compliance. A more confrontational approach is frequently counterproductive with clients suffering from a mental illness.

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CO-OCCURRING DISORDE

Overhead 4.8

STAGES OF TREATMENT #3: ACTIVE TREATMENT/RELAPSE PREVENTION

Integrated treatment approaches blend successful practices from substance abuse treatment and mental health treatment and add considerations for the interactive effects of substance use and mental illness. Therefore, effective integrated treatment may include the following components, depending on the specific nature of the mental illness and substance use:

Substance-related:

- · Individual, group, and family interventions
- · Behavioral contracting
- · Cognitive/behavioral relapse prevention
- Social skills training
- Day treatment
- Residential support
- Support group (DRA, AA, NA, etc.)
- Ongoing, comprehensive assessment of Mental Health issues

Mental Illness-related:

- Pharmacologic treatment of specific disorder
- Individual, family, or group therapy following best practice guidelines
- Outpatient treatment
- Case management
- · Diagnosis-specific group activities
- Ongoing, comprehensive assessment of Mental Health issues

Special considerations for integrated treatment:

- Interventions must be concrete in nature due to dual impairment
- 12-Step activities may require additional preparation due medication use
- · Incorporate general treatment elements as described

NOTES	

CO-OCCURRING DISORDERS

Overhead 4.9

STAGES OF TREATMENT #4: RECOVERY/REHABILITATION

Core concepts of recovery and rehabilitation:

- Continued maintenance
- Individual/group strategies to enhance empowerment and choice
- Emphasis on strengths, and involvement in social/vocational rehabilitation
- Step work/psychotherapy
- Supported housing models, sober houses
- Peer advocacy/peer counseling
- Self-help programs based on dual recovery concepts

(Source: CMHS Co-Occurring Mental and Substance Disorders Panel, 1998)

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CO-OCCURRING DISORDERS

Treatment Supplement 4.1

MENTAL ILLNESS OR SUBSTANCE ABUSE?

Below are phrases that are primarily descriptive of either mental health disorder or a substance use disorder. Have your group come to a decision about each phrase as it relates to either mental illness (MI) or substance abuse (SA). Please circle your groups' choice.

MI	SA	A BIOLOGICAL ILLNESS
MI	SA	CHRONICITY
MI	SA	HEREDITARY (IN PART)
MI	SA	INCURABILITY
MI	SA	LEADS TO LACK OF CONTROL OF BEHAVIOR AND EMOTIONS
MI	SA	POSITIVE AND NEGATIVE SYMPTOMS
MI	SA	AFFECTS THE WHOLE FAMILY
MI	SA	PROGRESSION OF THE DISEASE WITHOUT TREATMENT
MI	SA	SYMPTOMS CAN BE CONTROLLED WITH PROPER TREATMENT
MI	SA	DISEASE OF DENIAL
MI	SA	FACING THE DISEASE CAN LEAD TO DEPRESSION AND DESPAIR
MI	SA	DISEASE IS OFTEN SEEN AS A "MORAL ISSUE" DUE TO PERSONAL WEAKNESS RATHER THAN BIOLOGICAL CAUSES
MI	SA	FEELINGS OF GUILT AND FAILURE
MI	SA	FEELINGS OF SHAME AND STIGMA
MI	SA	PHYSICAL, MENTAL, AND SPIRITUAL DISEASE

TREATMENT OF

CO-OCCURRING DISORDERS

Treatment Supplement 4.2

TREATMENT MODELS

Persons diagnosed with mental illness and substance abuse present numerous challenges for existing treatment systems. Traditional community-based treatment programs often struggle to meet the multiple treatment needs of individuals with dual diagnoses. Co-occurring mental health and substance abuse disorders are interdependent and all disorders must be addressed in order to achieve long term recovery. Due to the unique treatment issues presented by these individuals, a variety of treatment models have evolved to treat the dually diagnosed.

Treatment models extend across the entire continuum of clinical services and intensity, but represent three underlying approaches: sequential treatment, parallel treatment, and integrated treatment. The sequential and parallel treatment models build upon existing mental health and substance abuse treatment systems and are considered appropriate for specific treatment needs. The integrated treatment model developed as a specific response to address complex, interactive nature of co-occurring disorders.

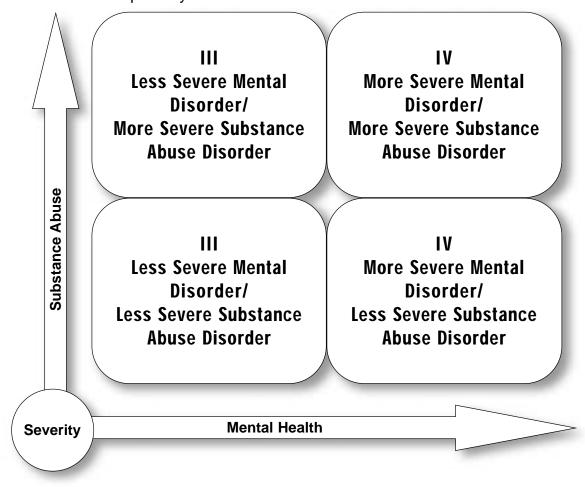
SEQUENTIAL	 First – and historically most common – model used Patient is treated by one system (addiction and mental health), and then by the other Differing views on which disorder to treat first; Treatment is dependent upon prioritization of disorders Financial coverage and confidentiality laws vary between systems May be appropriate for patients who have a severe problem with one disorder, and mild problem with the other Patients frequently receive conflicting therapeutic messages from two separate Systems
PARALLEL	 Simultaneous treatment provided to the patient by both mental health and addiction treatment settings Utilizes existing treatment programs and settings Financial coverage and confidentiality laws vary between systems Coordination of services between settings varies widely May be appropriate for patients who have a severe problem with one disorder, and mild problem with the other Patients frequently receive conflicting therapeutic messages from two separate Systems
INTEGRATED	 Combines elements of both mental health and addiction treatment into a unified and comprehensive treatment program for the patient Both disorders treated as primary Patient receives simultaneous treatment of both disorders in a setting designed to accommodate both problems Clinicians have typically received specialized training in dual disorders Patient no longer shoulders responsibility for integrating their care

TREATMENT OF CO-OCCURRING DISORDERS

Treatment Supplement 4.3

SEVERITY OF MENTAL HEALTH AND SUBSTANCE ABUSE DISORDERS

No single treatment approach can meet the needs of all individuals, therefore the appropriate course of treatment should be determined after careful consideration of consumer diagnoses and history, clinical severity, functional limitation, and available treatment resources. It is helpful to consider the severity of mental illness and substance abuse separately as shown below:



As shown in the figure, the severity of mental health and substance abuse disorders can vary independently on a continuum from low to high severity for each illness. As each illness increases in severity, the likelihood of harmful interaction and treatment complications increases. These simplistic categories may be used as a starting place for determining the appropriate treatment match or type of care.

CO-OCCURRING DISORD

It is worth noting that the nature and severity of the illnesses often dictate where a dually-diagnosed consumer receives care within the current treatment system. Current practice does not necessarily ensure optimum matching of patient needs with treatment opportunities, because consumers typically enter the treatment system with an imperfect knowledge of the available treatment options or their opportunities for care.

Category	Usual Treatment Location
I – Low MI, Low SA	Primary health care, community programs, no care at all
II – High MI, Low SA	Mental health system
III – Low MI, High SA	Substance abuse system
IV – High MI, High SA	State hospitals, jails, prisons, forensic units, emergency rooms, homeless service programs, mental health and/or substance abuse system, no care at all

(Source: NASADAD & NASMHPD, 1998, p. 13)

This pattern of service utilization highlights the fact that persons with co-occurring disorders receive care in a variety of settings, treatment and otherwise. Depending on the clinical facts of the case, the services provided by traditional mental health or substance abuse treatment environments may or may not be able to adequately address the multiple needs of dually diagnosed consumers. The most significant barrier to adequate treatment of co-occurring disorders is accurate identification and assessment of mental health and substance abuse issues.

CO-OCCURRING DISORDERS

Treatment Supplement 4.4

ASSESSMENT AND PLACEMENT STRATEGIES

Assessment

Current screening and assessment strategies used in mental health and substance abuse justifiably focus on mental health and substance abuse problems, respectively. This narrow focus, while efficient in a specialized treatment system, frequently misses co-occurring disorders of mental health and substance abuse. In practice, a comprehensive intake assessment in mental health typically includes extensive review of history and psychiatric symptomatology, while including only a cursory overview of substance use history. Mental health staff rarely have training or incentive to address substance abuse issues.

Likewise, a thorough intake assessment in a substance abuse treatment center will include an extensive review of the biological, psychological, and social sequelae of substance use, with only a cursory overview of psychiatric symptoms and mental health treatment history. Substance abuse staff rarely have training or incentive to address mental health issues.

As a consequence of these focused assessment strategies, persons with co-occurring disorders are not regularly identified in traditional mental health and substance abuse settings. Inadequate identification of potential treatment issues is likely to lead to poor treatment outcomes. This deficit can be addressed by improving identification and assessment of substance abuse issues in a mental health environment and by improved identification of mental health issues in substance abuse settings.

Additional sensitivity to identification of clinical issues is needed in all treatment settings, and can be accomplished through the use of reliable and valid screening instruments. For example, the CAGE questionnaire may be used as a substance abuse screening tool in a mental health setting and the Brief Symptom Inventory (BSI) may be used as a mental health screening device in substance abuse settings. A standardized mental status exam may also be a reliable indicator of mental health. If a patient exceeds a minimal threshold on a screening instrument, a more comprehensive assessment should be conducted. If the interviewer lacks sufficient expertise to conduct a more thorough assessment, an appropriate referral should be made to obtain a more comprehensive clinical evaluation.

CO-OCCURRING DISORDERS

Levels of Care

There are currently no standardized models for determining appropriate levels of care for patients with co-occurring disorders. A logical approach, however, may be based on the American Society of Addiction Medicine (ASAM) Patient Placement Criteria-2 used in substance abuse treatment. ASAM criteria recommend a multidimensional initial assessment considering the influence of substance, abuse, mental illness, and other factors on a patient's clinical status. An accurate initial assessment in the context of ASAM guidelines can then be used to make an appropriate treatment placement.

In recent years, the alcohol and other drug (AOD) abuse treatment field has begun the process of standardizing patient placement criteria (PPC). The goal is to establish uniform patient placement criteria (UPPC), accepted by all providers in the field, that can be used to accurately assess the severity of a patient's problems in three areas: medical, psychological, and social. Carefully developed UPPC will lead to effective placement of patients in appropriate levels of care. Such criteria can also be used as a basis for making decisions about moving patients through the continuum of treatment services as treatment progresses or relapses occur.

If UPPC are developed with the broadest possible input and are based on research and evaluation findings, they can be used to help ensure that:

- ▶ The Client's specific needs will be identified and a level of care will be chosen to fully address those needs
- ▶ A method is in place for continually improving the effectiveness of assessment, placement, and treatment
- Clinicians, using a common lexicon, can consult about clients or program characteristics without confusion
- ▶ The high cost of undertreatment is alleviated by ensuring that patients get all the treatment they needs, based on continued stay criteria rather than arbitrary monetary or time limitations.
- ▶ The high cost of overtreatment is alleviated by ensuring that patients get only the treatment they need, based on assessed needs and established criteria
- ▶ Common definitions of levels of care, common standards of assessment, and common standards for continued stay and discharge establish the same framework for public and private programs

CO-OCCURRING DISORD

The ASAM criteria provides the systematic framework to conduct a comprehensive biopsychosocial assessment that yields objective, clinically based patient placement decisions regarding the most appropriate level of care. These assessments and assignments to levels of care are based on six patient problem areas that are referred to as dimensions

> **Dimension 1:** Acute intoxication and/or withdrawal potential **Dimension 2:** Biomedical conditions and complications

Dimension 3: Emotional/behavioral conditions and complications

Dimension 4: Treatment acceptance/ resistance

Dimension 5: Relapse potential

Dimension 6: Recovery environment

Assessment and placement based on the six dimensions and the various levels of care formulate a treatment process designed to effectively address the specific needs of the patient. The overarching goal is to provide the most efficient and effective treatment possible with positive treatment outcomes.

A complete ASAM PPC-2 Manual may be purchased from:

American Society of Addiction Medicine. Inc. 4601 North Park Avenue Upper Arcade, Suite 101 Chevy Chase, MD 20815

Levels of Care: Special Considerations for Co-Occurring Disorders

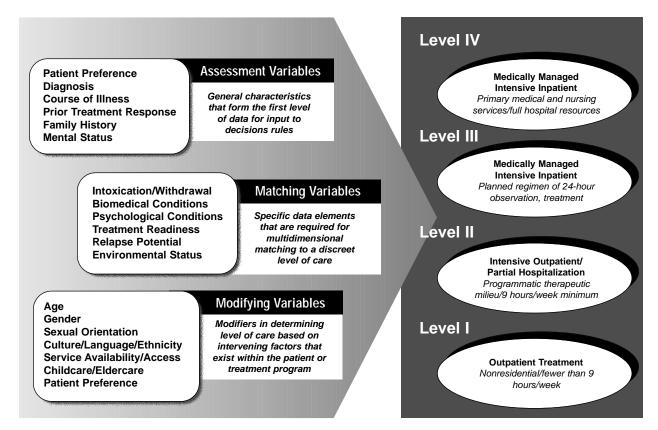
One should be cautioned that any use of assessment and/or treatment guidelines developed primarily for specific applications in mental health or substance abuse may not adequately consider the unique interactions commonly observed in co-occurring disorders. As difficult as it is to develop standardized assessment and treatment guidelines for a single disorder, it is considerably more challenging to predict the myriad of potential complications when working with a dually-diagnosed patient. Only a truly comprehensive and individualized assessment of patient needs can provide the information necessary to make well-informed decisions regarding optimal treatment modalities.

CO-OCCURRING DISORDERS

Patient placement criteria provide a link between assessment data and placement decisions. Guidelines that provide this link or start with a specific level of care can be considered patient placement criteria.

The state of Tennessee recognizes nationally developed criteria for the placement and treatment of AOD disorders as best practice. The American Society of Addiction Medicine Patient Placement Criteria-2 is the current publication of criteria implemented by state-funded treatment programs nationwide.

The ASAM criteria establish four levels of care which comprise a comprehensive continuum of care:



CO-OCCURRING DISORDERS

Treatment Supplement 4.5

GENERAL TREATMENT ELEMENTS

There is an emerging consensus that better integrated systems of care will benefit substance abuse and mental health services for all people seeking care, not just those with co-occurring disorders (Osher, 1996). Currently, however, substance abuse and mental health services are largely provided in separate treatment systems with separate funding sources and reporting requirements. Within this current framework, appropriate care can be administered by either substance abuse or mental health treatment centers as long as sufficient attention is given to the unique needs of individuals with co-occurring disorders.

Integrated treatment may be defined as simultaneous treatment of all disorders and it can be provided appropriately in many different contexts. Integrated treatment may be provided by a single, dually-trained clinician, or by a treatment team whose membership is competent to treat substance abuse and mental illness-related disorders. Ideally, team members should work within a single agency, but where necessary multiple agencies may collaborate to staff a unified team. This integrated team then has the charge to develop a treatment plan that addresses the interconnectedness and complexity of psychiatric and substance-related illnesses (National Advisory Council, 1997).

Several national panels of experts have suggested general elements comprising quality treatment for persons with co-occurring disorders, In 1997, SAMHSA convened a national advisory panel to develop a report on services for individuals with co-occurring disorders. That same year, NIDA produced a research monograph (#172) written by national experts to address issues related to dual diagnosis. Key treatment elements from these panel reports are summarized herein:

- Staff must be cross-trained in the treatment of co-occurring disorders. Continuity in treatment is critical, to avoid sending "mixed" messages to patients.
- Motivational enhancement techniques are used to facilitate engagement of patients, encourage progress toward abstinence by reframing maladaptive behavior and building self-efficacy.
- Behavioral intervention strategies may also be quite valuable in addressing fundamental training in social skills, symptom management, and behavior change.
- Case management is used to attend to the range of clinical, housing, social, or other needs that may be affected by either substance abuse or mental health problems.

CO-OCCURRING DISORDERS

CO-OCCORRING DISORDER

- Treatments must be appropriate and sensitive across culture, ethnicity, and gender.
- Treatment programs must take a long-term perspective that identifies and treats
 patients across stages of treatment, relapse, and recovery. This includes the
 recognition that treatment and recovery are not linear. Relapse is an inherent
 characteristic of chronic episodic disorders, and it is an expected feature in
 recovery from serious mental illnesses and substance use disorders.
- Specific interventions should be tailored to the patient's stage of recovery: engagement, persuasion, active treatment, or relapse prevention.
- Group interventions are used to provide peer support, persuade patients to address substance abuse behavior, and to share coping strategies.
 Psychoeducation is a critical part of this process, wherein patients can learn about their psychiatric disorders, the effects of substance abuse, and the interactive relationship of substance abuse and mental illness.
- Self-help groups serve a key role in encouraging recovery through peer relationships and mutual support. Self-help groups must be sensitive to issues of dual diagnosis (e.g., Dual Recovery Anonymous) or they can cause more harm than good.
- Where possible, treatment should involve the patient's social network and/or family members to address factors that maintain substance use, help patients progress toward personal goals, and bolster resistance to relapse.
- Treatment models should be based on rehabilitation and recovery concepts, as well as appropriate medical interventions, and which eschew judgmental and moralistic overlays.
- The development and use of therapeutic alliance to foster patient engagement in the treatment process, patient consistency in treatment, and positive treatment outcomes.
- A sense of optimism among staff. Data support the effectiveness of treatment for co-occurring disorders, with integrated approaches demonstrating the highest degree of effectiveness.

CO-OCCURRING DISORD

• The recognition that a small percentage of patients will require a high level of intensive treatment and related services, and that most patients/patients will respond to integrated services consistent with principles expressed herein.

A more complete discussion of these treatment elements can be found in:

National Advisory Council. (January, 1997). Improving Services for Individuals at Risk of, or with, Co-occurring Substance-related and Mental Health Disorders. (SAMHSA conference report submitted to SAMHSA and DHHS).

National Institute on Drug Abuse. (1997). Treatment of Drug-dependent Individuals with Comorbid Mental Disorders. NIDA Research Monograph #172. NIDA: Rockville, MD.

CO-OCCURRING DISORDERS

Treatment Supplement 4.6

STAGES OF RECOVERY AND TREATMENT STRATEGIES

Stages of Recovery and Treatment Strategies

Phases of treatment and recovery from co-occurring disorders of substance abuse and mental illness are largely parallel, including:

- Acute stabilization
- Engagement/Persuasion
- Active treatment/Relapse prevention
- Recovery/rehabilitation

A patient's progression through the recovery process rarely proceeds in an orderly, stepwise manner as might be suggested by these phases. The process of recovery can vary quite significantly based on individual differences and other mitigating factors, and patients frequently shift back to earlier stages in the process during a normal recovery. Each phase may be further subdivided into more specific elements if needed, but these stages are generally accepted by both mental health and substance abuse experts (CMHS Co-Occurring Mental and Substance Disorders Panel, 1998).

Integrated treatment can be administered at any stage in the recovery process, as long as staff are appropriately trained and have the resources to address issues related to both substance abuse and mental illness. The specific services required at each stage may differ in intensity and content, but the fundamental philosophy of integrated care dictates that both illnesses be considered primary and that continuity of care is critical. Minkoff and Rossi outlined a general framework for matching phases of recovery with appropriate treatment elements. Their framework, as presented in a report by the CMHS Co-Occurring Mental and Substance Disorders Panel (1998), follows:

Acute Stabilization:

Acute stabilization needs vary according to subtype of dual disorder, and acuity/severity of each diagnosis.

Individuals with SPMI and substance dependence, where both disorders are fully decompensated, will usually require hospitalization in an inpatient unit with dual diagnosis capacity. If the patient only requires detoxification, the patient may be managed in a psychiatrically-enhanced detoxification program. If the patient has only lapsed, but does not require detoxification, stabilization may

CO-OCCURRING DISOR

occur in a substance-capable crisis bed. In all of the above cases, appropriate medication for each disorder must be provided simultaneously in adequate dosages.

Individuals with SPMI and substance abuse who have psychiatric decompensation will require diagnosis capable inpatient or crisis beds. depending on severity. Detoxification should be required. Psychotropic medication is maintained.

Individuals with substance dependence and other psychiatric disorders, where both diagnoses are decompensated, require an integrated inpatient program with full addiction treatment capacity. If the psychiatric condition is more stable, but substance exacerbated, a psychiatrically-enhanced detoxification program is recommended. Less severe decompensations may be managed at lower levels of care.

Engagement/Persuasion:

Engagement techniques are similar across all dual disorder subtypes.

Pre-Motivational: Outreach, relationship building, collateral contacts, practical support, consideration of legal/coercive constraints and use when necessary.

Motivational: Motivational interviewing, motivational enhancement therapy, engagement groups (individuals and families), harm reduction strategies, behavioral contracting, empathic confrontation with consequences, education regarding disease and recovery, social network intervention.

Confrontation is empathic, caring, respectful, carefully planned and consistent with program policies and procedures that balance program requirements with sensitivity to consumer rights and needs.

Active Treatment/Relapse Prevention:

Treatment is specific to each diagnosis.

Substance Disorder

Substance Abuse: Individual, group, and family interventions; behavioral contracting; cognitive/behavioral relapse prevention; social skills training, day treatment, residential support.

CO-OCCURRING DISORD

Substance Dependence: All substance abuse interventions, plus intensive daily participation in a recovery program (AA, NA, Dual Recovery Anonymous, or other structured intervention), residential and/or day program focused on sobriety.

For both abuse and dependence, interventions are made more concrete for patients with more severe psychiatric and/or functional/cognitive disabilities. Gender-specific groups may be helpful.

Psychopharmacology and other psychiatric treatment is maintained throughout.

SPMI individuals can often be successful in 12 Step programs, when appropriately intensive training, preparation, and rehearsal is provided.

Psychiatric Disorder

Major Mental Illness (Schizophrenia, Bipolar, OCD, etc.): Pharmacologic treatment of specific disorder with best possible medication regime, plus individual, family, group, day, or residential treatment as indicated, with continuing case management. Diagnosis-specific dual diagnosis groups may be helpful.

Post-Traumatic Stress Disorder (PTSD): As above, plus specific individual and group work on trauma recovery and associated cognitive reframing and behavioral skills (Evans & Sullivan, 1995)

Attention Deficit Hyperactivity Disorder (ADHD)/Head-Injury: As above, plus specific cognitive interventions based on neuropsychological or functional assessment to promote learning and skill acquisition.

Borderline Personality Disorder: As above, plus specific individual and group work incorporating dialectic behavioral therapy or similar cognitive strategies.

Antisocial Personality Disorder/Impulsive, Aggressive Disorders: As above, with specific cognitive behavioral interventions in the context of correctional system oversight, or in a highly intensive residential setting (e.g., therapeutic community).

CO-OCCURRING DISORDERS

Recovery/Rehabilitation:

Recovery/rehabilitation strategies are similar for all subtypes:

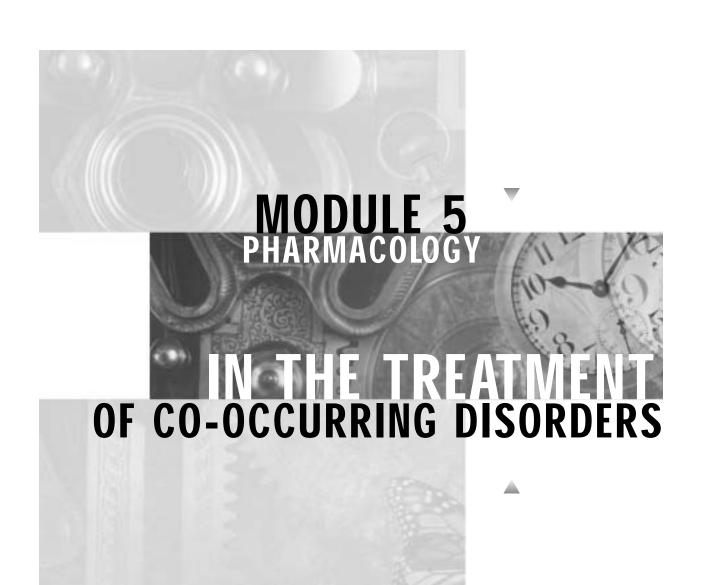
- continued maintenance
- individual/group strategies to enhance empowerment and choice
- emphasis on strengths, and involvement in social/vocational rehabilitation
- step work/psychotherapy
- club houses
- supported housing models, sober houses
- peer advocacy/peer counseling
- dual recovery self-help programs
- taper back any involuntary/coercive measure, increasingly empowering the consumer to take full responsibility for the recovery process"

(CMHS Co-Occurring Mental and Substance Disorders Panel, 1998)

CO-OCCURRING DISORDERS

Selected References for Treatment Concepts

- CMHS Co-Occurring Mental and Substance Disorders Panel (January, 1998). Cooccurring Psychiatric and Substance Disorders in Managed Care Systems: Standards of Care, Practice Guidelines, Workforce Competencies, and Training Curricula. Report of the Center for Mental Health Services Managed Care Initiative: Clinical Standards and Workforce Competencies Project. CMHS: Washington, DC.
- NASADAD and NASMHPD. (June 16-17, 1998). National Dialogue on Co-occurring Mental Health and Substance Abuse Disorders. (Report submitted to CSAT and CMHS).
- National Advisory Council. (January, 1997). Improving Services for Individuals at Risk of, or with, Co-occurring Substance-related and Mental Health Disorders. (SAMHSA conference report submitted to SAMHSA and DHHS).
- National Institute on Drug Abuse. (1997). Treatment of Drug-dependent Individuals with Comorbid Mental Disorders. NIDA Research Monograph #172. NIDA: Rockville, MD.
- Osher, F.C. (1996). A vision for the future: Toward a service system responsive to those with co-occurring addictive and mental disorders. American Journal of Orthopsychiatry, 66, 71-76.



OVERVIEW

A mental illness is a disease of the brain and an addiction is a disease of the brain caused by either too much or too little brain activity and/or brain chemistries. When patients with mental illness add drugs and alcohol to an already disturbed brain this causes even more chaos in thinking and behaviors. Psychotropic medications and abstinence and other psychotherapies correct the disturbance of brain chemistries. The task is to repair these errors by motivating patients to be A & D abstinent and by providing medication formulated to positively manipulate brain chemistries and brain activity to a state of balance and equilibrium, so that positive reception and participation in other therapeutic endeavors will create optimal healing opportunities.

Time Needed	1 Hour 20 minutes
METHODS:	Lecture (45 minutes) Discussion (20 minutes) Exercise (15 minutes)
GOAL:	To promote the participants understanding of the critical role of pharmacology in the management and recovery of co-occurring illness.
OBJECTIVES:	 By the end of module 5, participants will be able to: Recognize the workings of the brain Recognize the neuro-biological basis for mental illness and addiction Recognize the role of medication in the healing process. Illustrate that medication properly prescribed and monitored can positively impact the epidemic of addiction and chronic relapse typically seen in the mental health and addiction populations. Re-tool Professionals, Stakeholders and Clients with the knowledge that pharmacology is key in the treatment of co-occurring illness and that we must change our mindsets and attitudes based on a merging of treatment strategies and philosophies.
KEY POINTS:	 The key criterion for instituting pharmacology into treatment is that it alleviates the negative and undesirable behavioral symptoms in treatment and enhances other psychotherapeutic approaches.

	,
KEY POINTS: (con't.)	 The most successful treatment intervention combines pharmacology with psychosocial skill development. Major transmitter systems and neural pathways in the brain play very significant roles in the treatment as it relates to pharmacological intervention. Accurate diagnosis and past drug history is imperative before beginning a pharmacological regimen. Individuals who are addicted and relapse often, despite many treatment episodes, often have an underdiagnosed mental illness, which requires medication. Both mental illness and addiction is a disease of the brain. Use of pharmaceuticals is necessary to replace important chemicals that have been displaced, opening up or closing down strategic pathways in the brain necessary to restore health. The concept of reward (pleasure) is the property that is characteristic of many drugs. Dopamine is its natural counterpart in the brain. Pharmacology is the agent of healing. The brain is a functional unit of billions of nerve cells that communicate with each other using electrical and chemical signals which are interrupted in the course of mental illness and addictions/co-occurring disorders. Pharmacology is the agent that enables re-construction and restoration of health.
MATERIALS NEEDED:	 Prepared newsprint and easel Markers Tape Overhead Projector Screen Notepads and pencils Overhead transparencies Watch
OVERHEADS / NOTES:	 5.1 Objectives 5.2 Introduction to the Brain 5.3 Importance of Medication 5.4 Common Side Effects

	 5.5 Pharmacologic Risk Factors 5.6 Medicating the Co-occurring Disordered Patient 5.7 Noncompliance 5.8 Drug Interaction Causes 5.9 Key components of a Pharmacotherapy Contract
SUPPLEMENTS:	 5.1 The Brain 5.2 Philosophy of Medication 5.3 Medication Management 5.4 Medication Noncompliance 5.5 Interactions Between Drugs of Abuse Medications 5.6 Role of Pharmacotherapy/Medication in Recovery 5.7 Substances that cause Psychotic Symptoms 5.8 Pop Quiz #1 5.9 Pop Quiz #2

Overhead 5.1

OBJECTIVES

• Introduce the workings of the brain

Module 5: Pharmacology

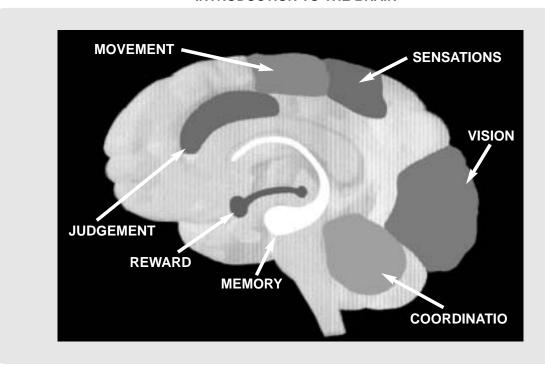
- Recognize the neuro-biological basis for mental illness and addiction
- Recognize the role of medication in the healing process.
- Illustrate that medication properly prescribed and monitored can positively impact the epidemic of addiction and chronic relapse typically seen in the mental health and addiction populations.
- Re-tool Professionals, Stakeholders and Clients with the knowledge that pharmacology is key in the treatment of co-occurring illness and that we must change our mindsets and attitudes based on a merging of treatment strategies and philosophies.

NOTES			

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Overhead 5.2

INTRODUCTION TO THE BRAIN



NOTES	 	

Overhead 5.3a

IMPORTANCE OF MEDICATION

- Needed are the special talents and the gracious expertise of clinicians cross-trained in addiction and mental illness
- The challenge of mental health and addiction providers to clear minds adequately enough to teach and motivate individuals with double denial that with quality treatment, they can have a better life
- Engaging individuals to pursue and continue to pursue treatment
- To stay on their medication and be alcohol and drug abstinent when they are additionally burdened with the stresses of a mental illness is a profound endeavor
- Success is achievable when there is a breakdown of denial coupled with the patient's acknowledgement of an improved level of internal and external comfort. This is the beginning of change and wellness

NOTES		
Module 5: Pharmacology	85	

Overhead 5.3b

- The chief challenge in treating the co-occurring population is to fashion a two-pronged treatment that gives equal care to the mental illness and the substance abuse.
- Sedatives help to prevent a full blown manic psychosis (hallucinations, delusions, extreme irritability, etc. as sedatives keep the brain from going through the ceiling into a psychotic state. Hypomania provides a false illusion of creativity and provides the individual with the wonderful feeling of euphoria. Therefore, the individual with a Bi-Polar illness has learned to manipulate brain chemistries with alcohol, pot or other sedatives to prevent the high developing into a psychosis and still maintain the desired pleasant effects of Hypomania. This activity takes a great deal of effort and the results are ultimately futile.
- An individual with a diagnosis of Bi-Polar illness coupled with addiction has double trouble as alcohol and street drugs are undoing what the medication is attempting to repair.
- It is fairly well accepted that the use of medications for mood stability is an essential component of patient care. While most experts agree that psychotherapy is an important adjunct to pharmacological interventions with affective disorder patients, there is less consensus concerning the most appropriate psychotherapeutic treatment. However, mood stabilization alone will not be an effective treatment for a substance use disorder. Adjunctive therapy and psychosocial rehabilitation is necessary.
- A wide range of psychotherapeutic interventions has been used in the treatment of affective disorders. These include psychodynamic, interpersonal, cognitive, behavioral and family therapy.

NOTES		
Module 5: Pharmacology	86	

Overhead 5.3c

- The clinician should acknowledge that dual diagnosed individuals may not consistently accept the diagnosis of schizophrenia, may vary in their willingness to maintain medication for schizophrenia, and may have greater or lesser motivation to stop their substance use.
- Attending to the role of motivation is important to the success of the treatment plan.
 Clinicians must work to strengthen patients' motivation while confronting the effects of schizophrenia and stressing the importance of medications in managing the schizophrenia.
- The therapist gives ongoing consideration to both substance abuse and psychiatric problems, monitors their interaction, and adjusts the treatment emphasis accordingly.
- Medications that best treat schizophrenia include the newer atypical anti-psychotic and depot neuroleptics.
- Dual diagnosis treatment addresses both problems simultaneously, conducts active
 outreach and case management efforts, attempts to increase client motivation for
 abstinence or harm reduction in a realistic manner, integrates mental health and
 substance abuse approaches, provides broad-based and comprehensive services, and
 remains flexible in responding to individual needs.

NOTES			
Module 5: Pharmacology	8	7	

Overhead 5.4a

	COMMON MEDICATION SIDE EFFECTS
SIDE EFFECTS	COPING MECHANISMS
Dry Mouth	Suck on hard citrus candies such as lemon or lime; increase the amount of water you drink and wash your mouth often with water. It often helps to melt bits of ice in your mouth. Avoid drinking high calorie beverages, such as soda, to prevent weight gain.
Blurred Vision	This is a temporary side effect which will stop when the medication is decreased or discontinued. Don't rush out and buy new glasses; give your eyes a chance to adjust.
Sleepiness	Keep active and involved. Sleepiness may indicate a need to reduce your medication after consulting your physician; sometimes the day-time dose will be lowered and the evening dose increased. Alcohol will increase the sedating effects of these medications.
Constipation	Increase your fluid intake; add bulk foods such as bran cereals and vegetables to your diet and exercise. If you continue to have problems with constipation, use a simple laxative or prune juice.
Difficulty Urinating	Your medication can be changed to solve this problem. Tell your doctor if you have this problem.
Dizziness or Faintness	Rest for a minute and then get up slowly. Dizziness should disappear. When lying down, sit for a while before standing up. Report this symptom to your physician.

NOTES			

Overhead 5.4b

Nasal Stuffiness	Tell your physician; he may reduce or change your medication.
Sensitivity to the Sun & Heat	This type of medicine will make you sweat less, making your body temperature increase. Be careful not to become overheated doing exercise in hot weather while you are taking this medication. If you are in the sun use a sunscreen or a suntan lotion with a rating of at least 15. Apply a sunscreen before you go out in the sun.
Menstrual Irregularities	Notify your physician.
Weight Gain and Fluid Retention	Watch your food intake or your medication may have to be changed.
Insomnia	Ask you physician if dose can be taken early in the day, preferable before noon. Do not exercise late in the day, and avoid heavy meals before bedtime.
Agitation	Sometimes, agitation occurs because of long-acting doses; ask your physician to consider every other day dosing.
Diarrhea	Minimize fat in your diet. Increase intake of bananas, rice, toast. Increase calcium intake.

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Module 5: Pharmacology

Overhead 5.5

PHARMACOLOGIC RISK FACTORS

- · Addiction is not a fixed and rigid event
- Like psychiatric disorders, addiction is a dynamic process, with fluctuations in severity, rate of progression, and symptom manifestation and with differences in the speed of onset.
- Both disorders are greatly influenced by several factors, including genetic susceptibility, environment, and pharmacological influences
- Certain people have a high risk for these disorders (genetic risk)
- Some situations can evoke or help to sustain these disorders (environmental risks)
- Some drugs are more likely than others to cause psychiatric or AOD use disorder problems (pharmacological risk)
- · Pharmacological effects can be therapeutic or detrimental
- · Medication often produces both effects
- Therapeutic pharmacological effects include the indicated purposes and desired outcomes of taking prescribed medications, such as a decrease in the frequency and severity of episodes of depression produced by antidepressants
- Detrimental pharmacological effects include unwanted side affects, i.e., dry mouth or constipation resulting from antidepressant use. Side effects perceived as noxious by patients may decrease their compliance with taking the medications as directed
- Some detrimental pharmacological effects relate to abuse and addiction potential. For example, some medications may be stimulating, sedating, or euphorigenic and may promote physical dependence and tolerance. These effects can promote the use of medication for longer periods and at higher does than prescribed

Prescribing medication involves striking a balance between therapeutic and detrimental pharmacologic effects. Therapeutic anti-anxiety effects of the benzodiazepines are balanced against detrimental pharmacological effects of sedation and physical dependency

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Overhead 5.6

MEDICATING THE CO-OCCURRING DISORDERED PATIENT

Coexisting addiction and mental illness perpetuate treatment problems and confound pharmaceutical intervention.

Co-morbidity takes many different forms in the dual diagnosed. To the casual observer, these individuals simply have addiction and psychiatric problems. However, the skilled counselor analyzes each case individually and determines the client's unique combination of problems. Research indicates that the most prevalent psychiatric diagnosis in this group is mood disorder, with depression, bipolar illness and schizophrenia also common. All of these diagnoses can be treated with prescription

Psychoactive Medication Used in the Dual Diagnosed

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	PSYCHIATRIC DIAGNOSIS	DRUGS USED	COMMON SIDE EFFECTS
	Schizophrenia	Moban, Haldol, Stelazine, Prolixin, Trilafon, Navane, Thorazine, Serentil, Loxitane Mellaril, Clozaril, Risperal	Dry Mouth, Blurred Vision, Sleepiness, Constipation, Difficulty Urinating, Dizziness or Faintness, Nasal Stuffiness, Sensitivity to Sun and Heat Menstrual Irregularities, Weight Gain & Fluid Retention
	Mood Disorders / Depression	Elevil, Pamelor, Tofranil, Vivacitil, Sinequan/Adapin, Norpramin, Asendin, Anafranil	Drowsiness, Dry Mouth, Constipation, Dizziness, Blurred Vision, Difficulty Urinating, Change in Blood Pressure, Skin Rash, Tremors, Jitteriness
	Anxiety / Withdrawal	Atrarax, Vistaril, Buspar, Librium, Valium, Ativan, Serax, Xanax, Holcion, Restoril, Inapsine, Klonopin	Drowsiness or Sedation, Headache, Lack of Interest, Dizziness, Fatigue, Nausea, Mild Sedation, Thirst
	Bipolar Illness	Lithium	Fine Tremors, Nausea, Mild Sedation, Thirst
		Depakene, Depakote, Tegretol	Nausea, Rash, Vomiting, Sedation

NOTES			

Overhead 5.7

NONCOMPLIANCE

Noncompliance: In the event of noncompliance, the patient should not be administratively discharged (i.e., rejected from treatment) but should instead be told that until abstinence has been safely established, pharmacotherapies must be withheld and the focus must rest on recovery attitudes and psychotherapeutic issues. This frustrating but supportive stance can be catalytic. If a course of treatment is ineffective after sufficient duration and dosage, or if covert substance use subsequently is discovered, the treatment plan should be revised, usually with revision of pharmacotherapies and modification of psychotherapies that have either erroneously neglected the primary anxiety or overlooked impending signs of relapse to addiction.

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Module 5: Pharmacology

Overhead 5.8

DRUG INTERACTION CAUTIONS

There are certain risks associated with AOD use and withdrawal among patients who are also being administered medications to treat psychiatric disorders.

- Alcohol and barbiturates can cause increased tolerance by impacting liver enzymes. Thus, serum levels of medications may be affected leading to mistakes regarding medication doses.
- 2. AOD and psychotropic medications combined may impact the body's ability to adjust body temperature.
- 3. Stimulants + monoamine oxidase inhibitor antidepressants can lead to life threatening hypertensive crisis.
- 4. Alcohol + cocaine enhances the respiratory depression effects of opioids and some neuroleptics.
- 5. Marijuana + anticholinergic medications can lead to anticholinergic psychosis.
- 6. Patients vulnerable to hallucinations are at high risk for having hallucinations during withdrawal from alcohol and other sedative-hypnotics.
- 7. Antipsychotics + antidepressants lower the seizure threshold and enhance seizure potential during withdrawal from sedative hypnotics and alcohol.

Alcohol intoxification and withdrawal disturbs electrolyte balance in the body which can lead to lithium toxicity.

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Overhead 5.9

KEY COMPONENTS OF A PHARMACOTHERAPY CONTRACT FOR THE CO-OCCURRING DISORDER PATIENT

- 1. Medication is part of a rational psychosocial treatment "package," and will be discontinued if key psychosocial components are neglected
- 2. Urine or blood testing may be required at any time to provide an independent source of data about the course of the chemical dependence, or to determine if prescribed medication is reaching adequate levels in blood.
- 3. Medication will be used only as prescribed. Any need for changes will first be discussed with the physician. A unilateral change in medication by the patient often is an early sign of relapse.
- 4. Changes in medication will be prescribed one at a time, e.g. two agents will not be initiated simultaneously.
- 5. When used, the purpose of medication is to treat predetermined target symptoms. If medication proves ineffective for these, it will be discontinued.
- 6. Once target symptoms remit, a process of dose tapering may be initiated to determine the minimum dose necessary to maintain health function. Periodically, the medication strategy will include a period of discontinuation, or "drug holiday." Medication may not be necessary on a long term basis.

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Module 5: Pharmacology

Supplement 5.1

THE BRAIN

- Certain parts of the brain govern specific functions. The sensory, movement, memory, cerebellum for coordination (vision), hippocampus for memory.
- Nerve cells or neurons connect one area to another via pathways to send and integrate information.
- The "reward" pathway illustrates how humans as well as other organisms engage in behaviors that are rewarding: the pleasurable feelings provide positive reinforcement, so the behavior is repeated. There are natural rewards as well as artificial rewards, such as drugs.
- Natural rewards such as food, water, sex and nurturing allow the organism to feel pleasure when eating, drinking, procreating and being nurtured. There is a pathway in the brain that is responsible for these rewarding behaviors.
- Activation of the reward pathway is achieved by an electrical stimulus. Specific brain areas, as well as neurochemicals are involved in the reward pathway.
 Interaction between drugs are addictive, they are cellular targets in the brain and the reward pathway.
- Drugs activate the reward system via increasing dopamine neurotransmission.
 Several drugs that have addictive potential, heroin (morphine) and cocaine
 activate the reward pathway, other drugs, such as nicotine and alcohol activate
 this pathway as well. While each drugs has a different mechanism of action, each
 drug increases the activity of the reward pathway by increasing dopamine
 transmission.
- Because of the way our brain's are designed, and because these drugs activate this particular brain pathway of reward, they have the ability to be abused. Thus, addiction is truly a disease of the brain.

Supplement 5.2

PHILOSOPHY OF MEDICATION

A harm reduction philosophy can be helpful and realistic with the poorly motivated client while he or she remains uncommitted and ambivalent about the goal of total abstinence. The patient who is in the pre-contemplation or contemplation stage of change often is unwilling to commit to total abstinence as a short-term goal. Keeping such a patient engaged in treatment often requires finding extrinsic motivators to further the development of the therapeutic alliance (these might include help with obtaining food, clothing, shelter, money management, vocational/training activities, social relationships, and the like) and the use of motivational interviewing to develop intrinsic motivation to stop using substances and to maintain compliance with psychiatric treatment.

Keeping patients engaged requires attempting to treat their illness and other addiction providing encouragement and other "rewards" for small steps toward reducing drug use. Evaluating outcomes other than total abstinence is required; for example, the clinician might assess the patient for reduced quantity and/or frequency of drug use, participation in treatment or other activities, <u>compliance with medications</u>, following up on short-term goals, and allowing family or significant others to be involved in treatment.

Supplement 5.3

MEDICATION MANAGEMENT

Antipsychotic medications are an important component in the treatment of schizophrenia. They are instrumental in reducing the long-term positive symptoms of the illness. The new atypical antipsychotics appear to reduce the negative symptoms of schizophrenia, and may also assist patients in the initial stage of abstinence from substances by reducing the severity of detoxification and early protracted abstinence symptoms.

Medications are not miraculous cure-alls, and this is especially true for a psychiatric illnesses such as schizophrenia, which is marked by complex symptoms and - more often than not- extreme social consequences. Thus, medications should be complemented by psychosocial therapy that engages clients, offers them practical training in interpersonal communication and crisis management, and develops their rehabilitation and recovery skills.

Medication management must first consider the best means for treating the schizophrenia or the chronic psychosis, followed by a consideration of the potential interactions between the substances abused and the possible medication choices. In general, clinicians should avoid prescribing medications that cause sedation when treating patients who abuse sedating substances. In addition, clinicians should generally avoid prescribing medications with abuse liability such as benzodiazepines.

Individuals known to have schizophrenia usually require the simultaneous administration of both antipsychotic medication and detoxification medications.

Patients presenting with active substance abuse, psychotic symptoms, and non-compliance can be difficult to manage as outpatients. Improving medication compliance in an outpatient setting can be enhanced through reducing positive and negative symptoms, providing psychoeducation and social skills training on medication management, using motivational enhancement techniques to improve compliance, and switching the route of administration of the medication from oral medication to long-acting injected medication, if patients are unable or refuse to take oral medications.

A fundamental treatment goal for these clients is to decrease and control their positive and negative symptoms through pharmacotherapy, thus allowing them to engage in psychosocial therapy and to integrate themselves into the community.

Once clinicians have chosen a treatment option that stabilizes the schizophrenia, they may consider the use of additional medication, as necessary, to manage comorbid depression, comorbid substance abuse, or another psychiatric problem. For substance use, medications are targeted for specific purposes, including detoxification, craving reduction, relief of protracted abstinence withdrawal, and agonist maintenance. Some adjunctive medications (such as antidepressants and mazindol) also may address the schizophrenia, helping to reduce and stabilize its negative symptoms. Despite the lack of pharmacotherapy trials among populations with a substance abuse problem and schizophrenia, a growing number of clinicians have reported the benefits of these medications.

The presence of negative symptoms, in particular, has long been considered a problem in treating the dually diagnosed. Researchers have theorized that negative symptoms may be wither a contributing factor in the development of substance abuse and in worsening the withdrawal symptoms. The "self medication" hypothesis proposes that some patients may use substances to cope with the negative symptoms of their schizophrenia. Clinical experience lends some support to this view, as patients often show an increase in negative symptoms during the initial phase of acute withdrawal as well as the succeeding antipsychotics medication may offer hope for improved treatment outcomes in medication jointly targets the schizophrenia and its negative symptoms. Nonetheless, the potential improved benefits of atypical on the dually diagnosed has yet to be reported using a randomized clinical trail, despite initial research that supports their effectiveness.

A second medication option is the use of long-acting injectable medications, e.g., Haldol decanoate® or Prolixin®. Although this option is frequently ignored, it effectively solves the problem of medication compliance, and thus may be an appropriate treatment for those patients whose motivation to quit using substances is low. Further research may yield a treatment that combines the comprehensive effectiveness of atypical medications with the compliance guarantees of injectable medications.

Once clinicians have chosen a treatment option that stabilizes the schizophrenia, they may consider the use of additional medication, as necessary, to manage comorbid depression, comorbid substance abuse, or another psychiatric problem. For substance use, medications are targeted for specific purposes, including detoxification, craving reduction, relief of protracted abstinence withdrawal, and agonist maintenance. Some adjunctive medication (such as antidepressants and mazindol) also may address the schizophrenia, helping to reduce and stabilize its negative symptoms. Despite the lack of pharmacotherapy trials among populations with a substance abuse problem and

schizophrenia, a growing number of clinicians have reported the benefits of these medications.

The administration of antabuse at higher dosages (1,000 mgs) has resulted in psychotic symptoms among non-dually-diagnosed patients. Naltrexone is a relatively safe medication that can be sued with patients who are at higher risk to relapse to alcohol; there is no alcohol-naltrexone reaction. Naltrexone's most common side effects includes headache and nausea. Naltrexone can precipitate opiate withdrawal, so clinicians should carefully assess patient's use of prescription or illicit opiates and be prepared to manage opiate withdrawal symptoms. Liver function tests should be monitored when using either disulfiram or natrexone.

For cocaine addiction among dually diagnosed patients, clinicians have tried a variety of augmentation medications, including desipramine, selegeline, mazindol, and amantadine, all of which aim to produce and increased dopaminergic effect that will reverse of compensate for the nuerophysiological changes stemming from the chronic use of cocaine. Unfortunately, no medication has been found to help reduce cocaine usage or craving among cocaine addicts without psychiatric comorbitity, and there are only a few studies that targeted individuals with schizophrenia and cocaine addiction.

Nicotine dependence traditionally has received less clinical attention and often has gone untreated. The recent development of treatment guidelines may correct this oversight and lead to the inclusion of tobacco dependence as a component in clinical treat plans (APA Practice Guidelines, 1996). In addition to multicomponent behavioral therapy, treatment for nicotine cessation may include adjunctive medications such as nicotine replacements (Transdermal patch, gun, spray or inhaler). Or bupropion. The new atypical antipsychotics may better treat negative symptoms and help in smoking cessation. In patients who are not receiving specific smiling cessation treatment, two studies found significant decreases in nicotine use among patients who were switched from traditional neuroleptics to clozapine. This study also showed that intensive psychosocial treatment (weekly individual motivational enhancement therapy combined with weekly relapse prevention group therapy) yielded better outcomes than either individual or group therapy alone.

Supplement 5.4

MEDICATION NONCOMPLIANCE

Prior to discussing specific medications and specific psychiatric diagnoses associated with dual diagnosis, it is important to note that medication noncompliance is a frequently observed phenomenon among dually diagnosed patients. Current substance abuse is strongly associated with medication noncompliance (Owen et al. 1996). Medication noncompliance is also associated with poor symptom outcomes. Interventions designed to decrease substance use should also incorporate efforts to decrease medication noncompliance.

Supplement 5.5

INTERACTIONS BETWEEN DRUGS OF ABUSE, MEDICATIONS AND NEUROBIOLOGY

- Both schizophrenia and addiction appear to have a primary neurobiological defect in the mesolimbic system (ventral tegmentum, nucleus accumbens, and pre-frontal cortex
- Substance abuse is generally associated with a more severe clinical profile, including indices of impairment, symptoms observed, and cognitive impairment
- Some substances can impact the metabilism of medications and reduce the therapeutic effect
- There are some reported positive effects by some patients, and substances may be more frequently used by the higher prognosis patients with social skills to obtain substances

From a biological perspective, the mesolimbic dopamine pathway appears to play an important role of reinforcement, pleasure and reward. But one must bear in mind that multiple pathways influence dopamine release, including the opiod system. The reward pathway has been identified as the dopamine pathway that includes the ventral tegmentum area, the nucleus accumbens, and the prefrontal cortex. The ventral tegmental area is linked to the prefrontal cortex, which some research has hypothesized may be hypoactive in schizophrenia. Therefore, chemical substances may be especially reinforcing in schzophrenics due to the combined stimulation of subcortical brain reward mechanisms and the prefrontal cortex.

In addition, substances can interact with pyschiatric medications used to treat the negative and positive symptoms of schizophrenia. The interactions are both pharmacokinetic and pharmacodynamic. Most of the substances of abuse interact with pyschiatric medications and reduce their effectiveness; some can alter medication blood levels and increase side effects.

Supplement 5.6

ROLE OF PHARMACOTHERAPY/MEDICATION IN RECOVERY

The key criterion for instituting pharmacotherapy for anxiety symptoms in an addicted patient is: Do symptoms seriously threaten the patient's function or recovery? It helps to operationalize this question with explicit treatment goals (such as stable job performance) and objective behavioral out comes (such as driving alone without avoidances). It avoids the moral and theoretical extremes of both pharmacologic Calvinism ("the only good drug is a dead drug") or pharmacologic Hedonism ("better living through chemistry"). In practice, these polar ideologies place patients at unnecessary risk, either influencing patients to reject psychotropics altogether or promoting iatrogenic substitute dependencies. Another ill-considered strategy is the use of the "pill transference," in which reinforcing agent are prescribed in an attempt to attach a handle to a hard-to-hold patient. A functional goal for pharmacotherapy fosters careful assessment of prior function, severity of target symptoms, recovery effort of the patient and the risk-benefit of pharmacologic agents.

Most pharmacotherapies require predictable pharmacokinetic (e.g., steady-state levels of medication) and pharmacodynamic (e.g., unperturbed neurotransmitter and receptor interaction) states in order to be effective.

Recovery Versus Abstinence

Recovery from chemical dependence is expressed as the process of restoring intrapsychic well-being and psychosocial function. In the patient with an anxiety disorder, recovery includes compliance with all treatment. As a general principal, pharmacotherapy alone is ineffective in the treatment of addicted patients and certainly in those patients with comorbid anxiety disorders.

Benzodiazepines are among the most commonly prescribed drugs in the U.S. Because they are themselves reinforcing, benzodiazepines pose a serious iatrogenic risk in this population, despite their efficacy and safety as anxiolytics for the general population.

Rapid onset benzodiazepines such as alprazolam, diazepam and lorazepam offer a degree of immediate gratification that appears to impede initiation of recovery efforts and retention of gains. In severe conditions that prove refractory to behavioral and antidepressant approaches, a slow-onset and long acting agent such as clonazepam may be the safest of this class. Yet, even clonazepam has addictive potential in severe

drug dependence. Thus, the use of benzodiazepines should be reserved for patients with well documented failure on antidepressants or other agents, who demonstrated continued distress and a commitment to treatment.

Serious abuse liability is present as the result of several mechanisms when benzodiazepines are used to treat substance-abusing or substance-dependent individuals; however, psychiatric patients are at greater risk and alcohol, sedative, cocaine and opiate-dependent or abusing individuals, including methadone maintenance patients, are at greatest risk. When their primary substance is unavailable, dependent individuals use benzodiazepines to substitute for alcohol, sedative or opiates, or to self-medicate withdrawal.

<u>Buspirone</u>: In contrast, buspirone has a high safety profile and has been proven in double blind trials to be as effective as benzodiazepines for primary anxiety or anxiety associated with depression. Buspirone, unlike the benzodiazepines and therefore is not appropriate as a withdrawal agent. In contrast, buspirone does not produce additive sedative or motor incoordination with other anxiolytics or alcohol, nor does it pose any dependency risk.

The drug's lack of dependence or abuse liability makes it an advance for the at-risk anxiety population.

Despite early caveats reserving its use for "benzodiazepines virgins," buspirone indeed is effective for generalized anxiety if the patient and family are vigorously educated and reminded about the slow onset and subtle perceptibility of its unique response. Most reports indicate benefit in substance dependence with anxiety symptoms.

Compliance requires ongoing assessment and reinforcement: buspirone and antidepressants require stable and predictable pharmacokinetic states (e.e., steady state levels of medication) in order to be effective.

<u>Antidepressants</u>: The antidepressants lack abuse liability, but some safety considerations are required in addiction patients. Tricyclic antidepressants have been the leading cause of medication overdose in the U.S. These agents therefore require assessment of suicide risk, adverse interactions with drugs of abuse (such as MAO inhibitors and beer or wine or cocaine) and cardiac toxicity. Tricyclic antidepressant levels must be monitored to confirm compliance and because chronic alcohol or nicotine consumption induces hepatic microsomal oxidation. Some newly abstinent anxious patients may be non-compliant with antidepressants in an attempt to procure benzodiazepines.

Both imipramine and trazodone have been reported in one controlled trial to relieve generalized anxiety symptoms as well as diazepam, without the risk of dependence. Trazodone, while overly sedating for use as an antidepressant, may be adjunctively useful for anxiety symptoms in benzodiazepines withdrawal and has been reported to reduce relapse risk, in comparison with placebo. An open trial in patients with substance dependence and anxiety (many with posttraumatic stress symptoms) found that trazodone 50 to 150 mg/d relieved anxiety and was associated with decreased use of benzodiazepines.

A parismonious benefit occurs if a patient is treated with serotonin uptake inhibitors, which have been shown to reduce excessive alcohol consumption.

Long-term studies are not yet available, however, and it is unclear to what extent "anticraving" pharmacotherapies will be effective in patients with severe substance dependence. In all cases, these agents should be prescribed in full antidepressant does with the expectation of a two-to-four-week onset of effect. A concern among the newer antidepressants is that many serotonin reuptake inhibitors exacerbate insomnia, whereas nefazodone may promote normalization of sleep cycle problems.

Another anxiety pharmacotherapy is the beta blocker, propranlol, which is effective in low doses (10 to 30 mg prn) for performance anxiety. There is no known abuse liability associated with this use and the risk of hypotension is minimal at these doses.

The essential principles are that pharmacotherapy target specific symptoms, is timelimited, is modified only one change at a time, is monitored for compliance, and is provided only in the context of a comprehensive psychosocial treatment plan.

Noncompliance: In the event of noncompliance, the patient should not be administratively discharged (i.e., rejected from treatment) but should instead be told that until abstinence has been safely established, pharmacotherapies must be withheld and the focus must rest on recovery attitudes and psychotherapeutic issues. This frustrating but supportive stance can be catalytic. If a course of treatment is ineffective after sufficient duration and dosage, or if covert substance use subsequently is discovered, the treatment plan should be revised, usually with revision of pharmacotherapies and modification of psychotherapies that have either erroneously neglected the primary anxiety or overlooked impending signs of relapse to addiction.

One of the roles proposed for the pharmacotherapy of addictions has been that of trigger reducers; that is, agents to reduce anxiety symptoms that might provoke relapse. This

role is controversial because of a theoretical conflict with the abstinence goal: "the only good drug is a dead drug." **Medications are widely used as trigger reducers.**

Among the anti-anxiety agents, only buspirone has the acceptable combination of non-reinforcing, efficacy and safety features. Among the sleep agents, trazodone is unique in that it may correct sleep architecture disruptions, such as REM rebound, that are common during the early ethanol and benzodiazepines post-withdrawal phase.

- 1. Brief benzodiazepines treatment to reduce vigilance and permit initiation of *in vivo* exposure therapy, plus
- 2. Antidepressant therapy to stabilize locus ceruleus firing and reduce limbic system alarm, plus
- 3. A cognitive behavior therapeutic approach to correct misperceptions of otherwise un-provocative stimuli such as streets and crowds, plus
- 4. A dynamically oriented psychotherapeutic approach to reduce the patient's stress from interpersonal friction.

In the patient with associated substance dependence or abuse, the synthetic approach is needed to a greater extent to take into account the following additional needs:

- 5. Pharmacologic and psychosocial treatment of substance withdrawal, plus
- 6. Psychoeducation, motivational enhancement and relapse prevention stabilization of abstinence, plus
- 7. Recovery lifestyle changes to promote predictable daily structure, sober supports and lifelong awareness of vulnerabilities, plus
- 8. Non-reinforcing pharmacotherapy of anxiety (e.g., buspirone) and trigger symptoms (e.g. trazodone for insomnia);
- 9. Anti-appetitive pharmacotherapy, as for alcoholism (e.g., buspirone) and trigger symptoms (e.g. trazodone for insomnia);
- 10. Pharmacotherapeutic contracting to enhance compliance and avoidance of reinforcing agents such as benzodiazepines.

A well-coordinated multi-modal team approach can successfully help the patient restore an adaptive balance, allowing him or her to tolerate anxiety as an expected feature of adult life, with stable recovery, constructive coping and life-long growth.

Supplement 5.7

SUBSTANCES THAT CAUSE PSYCHOTIC SYMPTOMS

During Intoxication:

- Sedatives (alcohol, benzodiazephines, and barbiturates)
- Stimulants (amphetamine, ice, cocaine)
- Designer drugs (exstacy, etc.)
- Marijuana/THC
- Hallucinogens (LSD, Ketamine, psilosibine, etc.)
- Opiods
- Phencyclidines

During Withdrawal:

- Sedatives (alcohol, benzodiazepines, and barbiturates)
- · Anesthetics and analgesics
- · Anticholinergic agents
- Anticonvulsants
- Antihistamines
- Antihypertensives
- · Antimicrobial medications
- AnitParkinsonian medications
- Cardiovascular medication
- · Chemotherapeutic agents
- Corticosteriods
- Gastrointestinal medications
- Muscle relaxants
- Non-steroidal anti-inflammatory drugs (NSAIDs)
- Over-the-counter drugs
- Toxins (Anticholinesterase, organophosphate insecticides, nerve gases, carbon monoxide and volatile substances such as fuel or paint).

Supplement 5.8

POP QUIZ #1

- As an individual is going through recovery, are there any circumstances to use medications? If yes, when? (NOTE: Please do not include in your answer methadone or LAAM treatment protocols.)
- 2. For patients with Co-Occurring illnesses, which is an effective approach to use for a positive outcome?
 - a) Cross trained clinicians
 - b) Behavioral therapy
 - c) Motivational Enhancement
 - d) Pharmacology
- 3. What happens when a patient is taking medication along with alcohol and drugs:
 - a) This confuses the brain
 - b) Difficult to make true diagnosis
 - c) Patient has to be detoxed
- 4. True or False: Individuals are diagnosed with alcohol or drug related psychoses that are hospitalized in a psychotic state and then clear symptoms rather quickly.
- 5. True or False: Patients with an A & D history who do not clear after detoxification, most likely have a serious underlying mental illnesses.
- 6. True or False: A & D use with medication does not exacerbate mental illnesses.

Supplement 5.9

POP QUIZ #2

1.	You are a participant in learning more aboutspecifically as it relates to the importance ofin the stabilization and healing process.
2.	What are the two diseases of the brain that can be alleviated with proper dosages of medication and other psychopharmacological techniques based on the features of the disease.
	I
	II
3.	Name three common side effects of medication.
	I
	II
	III
4.	True of False: Medication can make a profound difference in the outcome of treatment for Co-Occurring illness.
5.	The chief challenge in determining a pharmaceutical regimen to a Co-Occurring patient is
6.	After accurate diagnosis, what are the two most important tasks with the medication for the provider.
	l
	II
7.	The voluntary or involuntary inability of a client to take medication as prescribed is called
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MODULE 6 COLLABORATIVE SYSTEMS





OVERVIEW

In order to meet the comprehensive needs of individuals with co-occurring disorders, professionals must build a system that integrates the medical, social and practical needs of clients. Collaborative systems are built at two levels; the community level and the provider level.

An effective collaborative system includes both community and provider components and must include the review of needs in key life domains of:

- Housing
- Financial
- Physical Health Care
- Vocational/Educational
- Social Integration/Support, including Family and Natural Support Systems
- Legal

Access to and coordination of these life domains is often challenged by the fragmentation of natural supports and social service supports from the treatment arena, but coordination must be assured by the treatment professional in order for achievement of successful client outcomes and recovery. In addition, individuals with a co-occurring disorder may face additional barriers due to social stigma related to these disorders; effective planning and collaboration can positively impact the community's view of the population and decrease the number of barriers that limit access to needed services.

Time Needed	1 hour
Methods:	Lecture (30 minutes) Discussion (30 minutes)
Goal:	To define the role, scope and mechanisms for support services in supporting treatment of those individuals with co-occurring disorders and apply those principles to one's practice.
Objectives:	 By the end of module 6, participants will be able to: Define the key life domains of collaborative systems and key values of community based care. Identify the unique needs and characteristics of individuals with a co-occurring disorder that impact coordination of and access to services. Define coordination, reasons for and major mechanisms

COLLABORATIVE SYSTEMS

	 for coordinating treatment services with support services. Identify a process for assessing their agencies and communities strengths and weaknesses for coordination of care and identify a process to improve upon collaboration in their practice and community.
Key Points:	 Collaboration and coordination of treatment and support services is a pivotal factor for successful client outcomes and recovery and must occur in order to address the multiple needs of clients with co-occurring disorders.
Materials Needed:	 Prepared newsprint and easel Markers Tape Notepads and pencils Overhead projector Screen Overhead transparencies Watch Coordination of Alcohol, Drug Abuse and Mental Health Service (TAP 4) Comprehensive Case Management for Substance Abuse Treatment (TIP 27)
Overhead / Notes:	 6.1 Module Objectives 6.2 Common Characteristics 6.3 Life Domains 6.4 Definition of Coordination 6.5 Reasons for Coordination 6.6a Major Mechanisms for Coordination 6.6b Major Mechanisms for Coordination 6.7 Six Steps for Developing Coordination
Supplements:	 6.1 SelfAssessment 6.2 SelfAssessment Action Plan 6.3 Helpful Hints
Prepared Newsprints:	 6.1 Common Characteristics of Individuals With Co- Occurring Disorders 6.2 Barriers to Coordination

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Overhead 6.1

MODULE OBJECTIVES

Objective 1

• Define the key domains of collaborative systems and key values of community based care.

Objective 2

• Identify the unique needs and characteristics of individuals with a co-occurring disorder that impact coordination of and access to services.

Objective 3

 Define coordination, reasons for coordination and major mechanisms for coordinating treatment services with support services.

Objective 4

 Identify a process for assessing their agencies and communities strengths and weaknesses for coordination of care and identify a process to improve upon collaboration in their practice and community.

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COMMON CHARACTERISTICS OF INDIVIDUALS WITH A CO-OCCURRING DISORDER

- Often un- or under- employed
- · Lack job skills or work experience, or education has been interrupted
- Face barriers in accessing safe and affordable housing
- Often alienated families, friends or have peer affiliations that hamper treatment efforts
- Women are often victims of violence (domestic abuse, sexual abuse, rape)
- · Multiple medical needs often not or under- addressed
- Often been through many courses of treatment and may be viewed as treatment resistant/non-compliant
- Often have legal complications

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Module 6: Collaborative Systems

COLLABORATIVE SYSTEMS

Overhead 6.3

LIFE DOMAINS

Housing

Where and with whom a person lives, reflecting adequacy of environment, ability to manage personal and household tasks, degree of independence, degree of satisfaction, and any positive or negative perceived impact on the person's physical and/or emotional status.

Financial

Amount and source of income reflecting adequacy for the person's needs, the person's ability to manage money effectively and/or eligibility for entitlements.

- Physical Health Care
 - A person's physical health, reflecting any medical problems, adequacy of or need for treatment, ability to follow medical regime and impact on emotional/mental stability.
- Vocational/Educational

A person's educational and vocational history, current status, desired educational/vocational goals and need for skill development to attain those goals.

- Social Integration/Support, including Family and Natural Support Systems
 A person's community and social/leisure support system (family, friends, organizations), reflecting
 the degree of integration into natural support system as opposed to dependence on the treatment
 delivery system, isolation, or negative social/leisure pursuits.
- Legal

A person's legal history, current status and need for intervention to address outstanding issues or to prevent further negative contacts.

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COLLABORATIVE SYSTEMS

Overhead 6.4

COORDINATION

(ko ôr' de na shen)

The degree to which collaboration and exchange exists among an aggregation of service providers so that services may be provided in a meaningful, appropriate sequence.

3 RELATED CONCEPTS:

Comprehensiveness

Deals with whether a set of services is complete, that is, whether all the necessary resources and types of help are present and available to individuals to meet all their needs.

· Continuity of Care

Focused on the patient level and refers to maintaining a chain of professional responsibility as the patient moves from one program to another to receive needed services. Two dimensions and goals to continuity of care:

- 1. Cross-sectional: Services provided to a person at any given time is comprehensive and coordinated.
- 2. Longitudinal: The system provides comprehensive, integrated services over time and is responsive to changes in the person's needs.
- Integration of Services
 Integration is a focus is on the "organizational level" and refers to the attempt to bring
 together agencies and programs into a single system.

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REASONS FOR COORDINATION

1. FRAGMENTATION

Agencies operate separately and do so with different goals, objectives and philosophies. Agencies employ different eligibility criteria and treatment approaches.

Result:

- · Service access is difficult for clients.
- Confusion for those clients who are able to access services under two agencies.

2. DUPLICATION

Services tend to overlap and duplicate one another.

Result:

- Less efficiency for clients.
- · Increased costs.

3. NO PROVISION FOR MULTIPLE NEEDS

Typically agencies do not provide a wide range of services to respond to the complex needs of some individuals. Agencies are not often fully aware of other agencies other than a general idea of their services and their location.

Result:

· May not get the person to the right place or may not receive what they need.

4. NO ACCOUNTABILITY

Lack of accountability when someone is served by different/several agencies.

Result:

· Clients may not be fully benefiting from services.

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COLLABORATIVE Systems

Overhead 6.6a

MAJOR MECHANISMS FOR COORDINATION

- Case Management
 A method or process for ensuring that persons are provided needed services in a coordinated, effective and efficient manner through the use of a case manager and core service agency.
- Co-Location
 Placement of the deliverers of services from a number of different agencies in the same physical setting.
- Information and Referral
 A system for directing people needing assistance to agencies that meet their needs.
- Centralized Intake and Referral Provision of a single point for access to a full range of services
- Multidisciplinary Teams
 Provision of multiple linked services through the inclusion of different service professionals on a team.
- Sharing Staff
 An arrangement through which two or more agencies share the services of the same

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COLLABORATIVE Systems

Overhead 6.6b

MAJOR MECHANISMS FOR COORDINATION (cont)

INTERAGENCY NETWORKS

A specific set of linkages among a defined set of services agencies. There are three types:

- Multidisciplinary Teams: Provision of multiple linked services through the inclusion of different service professionals on a team.
- Bilateral Coordination: Two agencies working together.
- Multilateral Coordination: Multiple agencies developing agreements to work together.

• FINANCING MODELS

The use of funding arrangements to encourage coordination such as incentive programs, local entities to manage funding of services and capitation of funds.

EDUCATION AND TRAINING

Conferences, seminars, educational forums, professional training programs and other types of instructional approaches offer a means of teaching the value of coordination.

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COLLABORATIVE Systems

Overhead 6.7

SIX STEPS FOR DEVELOPING COORDINATION

- 1. Assess the Current Environment
- 2. Build Support for Coordination
- 3. Design a Coordinated Program
- 4. Implement the Program
- 5. Evaluate the Program
- 6. Adjust the Program and Build Sustainability

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COLLABORATIVE SYSTEMS

Supplement 6.1

SELF ASSESSMENT

Facilitating the client's utilization of available support systems and community resources

Knowledge Of:	Excellent	Good	Fair	Poor
Community demographics, including political and cultural systems.	XOUNCIT	2000	· un	. 301
The range of service providers and services offered in your community.				
How to access services according to agency and type of service, including referral				
criteria and protocols.				
Confidentiality regulations, particularly by provider.				
Effective communication styles and methods.				
Needs of the client population served.				
Client motivation and ability to initiate and follow through with referrals.				
Factors in determining the optimal time to engage client in the referral process.				
Empowerment techniques.				\vdash
Comprehensive treatment planning.				
Methods of assessing client's progress toward treatment goals. How to tailor resources to client treatment needs.				
How to access key resource persons in the community.				
How treatment planning and referral relate to the goals of recovery.				
How client defenses, abilities, personal preferences, cultural influences,				
presentation and appearance effect referral and follow through.				
Appropriate sources and techniques for evaluating referral outcomes.				
Skills In:				
Networking and communication.				
Advocating for clients.				
Using existing community resource directories, databases, etc.				
Working with others at part of a team.				
Establishing and nurturing collaborative relationships with key contacts in				
community organizations.				
Giving feedback to community resources regarding their service delivery.				
Interpreting assessment and treatment planning materials to determine				
appropriateness of client or counselor referral.				
Assessing the client's readiness to participate in the referral process.				
Educating the client regarding appropriate referral processes.				
Motivating clients to take responsibility for referral and follow-up.				
Using written and verbal communication for successful referrals.				
Maintaining follow-up activity with the client				
Collecting objective and subjective data on the referral process.				
Attitudes:				
Respect for client's:				
needs and				
ability to initiate and follow-up with referral				
Respect for interdisciplinary, comprehensive approaches to meet client needs.				
Respect for collaboration and cooperation.				
Patience and perseverance.				
Respect for confidentiality regulations.				
Willingness to advocate on behalf of the client.				<u> </u>
Willingness to share decision-making power with the client				
Respect for the goal of positive self-determination.				
Awareness of personal biases toward referral sources.				\vdash
Appreciation for the need to exchange relevant information with other professionals.				
Appreciation of the value of inter-agency collaboration.				
The solution of the value of the agone, collaboration.				



Supplement 6.2

SELF ASSESSMENT ACTION PLAN

Facilitating the client's utilization of available support systems and community resources

From the self-assessment what areas can you address that would increase your effectiveness in facilitating the client's utilization of available support systems and community resources.

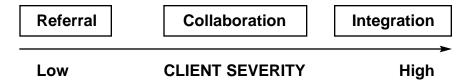
•	What Areas	How to Accomplish This
Knowledge		
Skills		
Attitudes		



Supplement 6.3

HELPFUL HINTS

The severity of the person's disorder typically defines whether you use referral, collaboration or work within an integrated system for providing service to this population. The appropriate choice of interaction will be reflected in an improvement in client outcomes.



Process of facilitating the client's utilization of available support systems and community resources to meet needs identified includes the following items:

- Establish and maintain relationships with civic groups, agencies, other
 professionals, governmental entities, and the community at large to ensure
 appropriate referrals, identify service gaps, expand community resources and
 help to address unmet needs.
- Continuously assess and evaluate resources to determine their appropriateness.
- Differentiate between situations in which it is most appropriate for the client to self-refer/link to a resource and instances requiring counselor referral/linkage.
- Arrange referrals/linkages to other professionals, agencies, community programs, or other appropriate resources to meet client needs.
- Explain in clear and specific language the necessity for and the process of referral/linkage to increase the likelihood of client understanding and follow through.
- Exchange relevant information with the agency or professional to whom the referral/linkage is being made in a manner consistent with confidentiality regulations and generally accepted professional standards of care.
- Evaluate the outcome of the referral/linkage.

Source: Adapted from TIP 27, Appendix B

System Improvement Begins With YOU!